Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your 2022 Contract Code: 6BC1

Your Plan: Anthem Bronze Choice PPO 6000/25%/7000 w/HSA

Your Network: Choice PPO

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Covered Medical Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$6,000 person / $12,000 family	$6,500 person / $13,000 family	$13,000 person / $26,000 family
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.*	$7,000 person / $14,000 family	$7,000 person / $14,000 family	$14,000 person / $28,000 family
Preventive care/screening/immunization *Preferred Network and In-Network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	No charge	50% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	No charge	50% coinsurance after deductible is met
Virtual Care (Telemedicine / Telehealth Visits)			

Your summary of benefits

Covered Medical Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Virtual Visits with Doctors who also provide services in person			
Primary Care (PCP)	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Mental Health and Substance Abuse care	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Specialist	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Medical Chats and Virtual (Video) Visits for Primary Care *from our Online Provider K Health, through its affiliated Provider groups*	No charge after deductible is met		
Virtual Visits from Online Provider LiveHealth Online - *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*			
Primary Care (PCP) and Mental Health and Substance Abuse	25% coinsurance after deductible is met		
Specialist Care	25% coinsurance after deductible is met		
Visits in an Office			
Primary Care (PCP)	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Specialist Care	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Other Practitioner Visits			
Routine Maternity Care (Prenatal and Postnatal) *Preferred Network and In-Network preventive prenatal and postnatal services are covered at 100%.*	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Retail Health Clinic	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Spinal Manipulation *Coverage is limited to 50 visits per benefit period. Limit is combined Preferred Network, In-Network and Non-Network across all settings.*	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Acupuncture	Not covered	Not covered	Not covered
Other Services in an Office			
Allergy Testing	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Chemo/Radiation Therapy	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Dialysis/Hemodialysis	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Prescription Drugs - Dispensed in the office *For the drugs itself dispensed in the office through infusion/injection.*	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Surgery	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Diagnostic Services			
Lab			
Office	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Lab/Reference Lab	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
X-Ray			
Office	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging - for example: MRI, PET and CAT scans			
Office	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency and Urgent Care			
Urgent Care (Office Setting)	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency Room Facility Services	25% coinsurance after deductible is met	25% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	25% coinsurance after deductible is met	25% coinsurance after deductible is met	Covered as In-Network
Ambulance (Air and Ground) *Non-emergency, Non-Network ambulance services are limited to an Anthem maximum payment of $50,000 per trip.*	25% coinsurance after deductible is met	25% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse			
Doctor Office Visit	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Facility visit			
Facility Fees	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Surgery			
Facility Fees			
Hospital	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and Other Services			
Hospital	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospital Stay (all Inpatient stays including Maternity, Mental Health and Substance Abuse)			
Facility fees (for example, room & board) *Coverage for Inpatient Rehabilitation is limited to 60 days per benefit period. Limit is combined Preferred Network, In-Network and Non-Network.*	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and other services	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Recovery & Rehabilitation			
Home Health Care	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy)			

Your summary of benefits

Covered Medical Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Coverage for physical therapy, occupational therapy and speech therapy is limited to 120 visits combined per benefit period. Limit is combined Preferred Network, In-Network and Non-Network across all settings.			
Office	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Habilitation services (for example, physical/speech/occupational therapy)			
Coverage for physical therapy, occupational therapy and speech therapy is limited to 120 visits combined per benefit period. Limit is combined Preferred Network, In-Network and Non-Network across all settings.			
Office	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation			
Office	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Pulmonary rehabilitation			

Your summary of benefits

Covered Medical Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Office	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (in a facility) *Coverage is limited to 150 days per benefit period. Limit is combined Preferred Network, In-Network and Non-Network. Limit is combined across a skilled nursing facility and an outpatient day rehabilitation program.*	25% coinsurance after deductible is met	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Inpatient Hospice	No charge after deductible is met	No charge after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment	50% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period. Limit is combined Preferred Network, In-Network and Non-Network. Coverage for hearing aids services is limited to 1 item per ear every 3 years. Limit is combined Preferred Network, In-Network and Non-Network across all settings.*	50% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with Non-Network medical deductible
Pharmacy Out of Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Prescription Drug Coverage *Cost shares for drugs included on the Select drug list appear below. Drugs not included on the Select drug list will not be covered. Your plan uses the Advantage Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies.*		
Home Delivery Pharmacy *Maintenance medications are available through IngenioRx Home Delivery Pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.*		
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	25% coinsurance after deductible is met (retail and home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	25% coinsurance after deductible is met (retail and home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	25% coinsurance after deductible is met (retail and home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) *Per 30 day supply (specialty pharmacy).*	25% coinsurance after deductible is met (retail and home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)

Your summary of benefits

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. Not all cost shares for covered services are shown below. Benefits include coverage for member's choice of eyeglass lenses or contact lenses, but not both. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. *Only children's vision services count towards your out of pocket limit.*		
Children's Vision Essential Health Benefits (up to age 19)		
Child Vision Deductible	Not Applicable	Not Applicable
Vision exam *Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Frames *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Single Vision Lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Bifocal Vision Lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Trifocal Vision Lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Elective contact lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Non-Elective Contact Lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Adult Vision (age 19 and older)		
Adult Vision Deductible	Not Applicable	Not Applicable
Vision exam	$20 copay	Reimbursed Up to $30

Your summary of benefits

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.		
Frames	Not covered	Not covered
Single Vision Lenses	Not covered	Not covered
Bifocal Vision Lenses	Not covered	Not covered
Trifocal Vision Lenses	Not covered	Not covered
Elective contact lenses	Not covered	Not covered
Non-Elective Contact Lenses	Not covered	Not covered

Your summary of benefits

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your dental coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. *Only children's dental services count towards your out of pocket limit.*		
Children's Dental Essential Health Benefits **Diagnostic and preventive** *Coverage for In-Network Providers and Non-Network Providers is limited to 2 visits per 12 months.*	No charge	30% coinsurance deductible does not apply
Basic services	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Major services	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Medically Necessary Orthodontia services	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Cosmetic Orthodontia services	Not covered	Not covered
Deductible	Combined with medical deductible	Combined with medical deductible
Adult Dental		
Diagnostic and preventive	Not covered	Not covered
Basic services	Not covered	Not covered
Major services	Not covered	Not covered
Deductible	Not covered	Not covered
Annual maximum	Not covered	Not covered

Your summary of benefits

Notes:

- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.
- You are encouraged to select a Primary Care Physician (PCP). Choosing a PCP is an important decision. Call us at the number on your ID card and we'll help you pick a doctor.
- For additional information on this plan, please visit www.sbc.anthem.com to obtain a "Summary of Benefits and Coverage".
- If services are rendered by a non-participating provider and your plan includes out of network benefits, you may be responsible for any difference between the covered plan payment and the actual non-participating provider's charge.
- All medical services subject to a coinsurance are also subject to the annual medical deductible.
- If your plan includes out-of-network coverage, covered out-of-network Human Organ and Tissue Transplant services do not apply toward the out-of-pocket limit.
- If your plan includes out of network benefits and you use a non-participating provider, you are responsible for any difference between the covered expense and the actual non-participating provider's charge. Except for out-of-network emergency services from a professional or facility inside Nevada, when receiving care from providers out-of-network, members may be subject to balance billing in addition to any applicable copayments, coinsurance and/or deductible. This amount does not apply to the out-of-network out-of-pocket limit.
- Vision services are not subject to the annual deductible.
- Emergency Care you receive from an Out-of-Network Provider will be covered as an In-Network service. But, you may have to pay the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount, as well as any applicable Coinsurance, Copayment or Deductible.
- Benefit period refers to calendar year.
- Your copays, coinsurance and deductible count toward your out of pocket amount.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.
- All covered services cost shares for both Preferred Providers and In-Network Providers apply to the In-Network out-of-pocket maximum.

Language Access Services:

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (855) 330-1218

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

(TTY/TDD: 711)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على 330-1218 (855) .

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (855) 330-1218:

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Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'idiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí łą' bich'į' hadeesdzih ninízingo kojį' hodíilnih (855) 330-1218.

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