Your summary of benefits

Anthem BlueCross BlueShield

Anthem Blue Cross and Blue Shield

Your Plan: Anthem Silver PPO 3000/30%/5000

Your Network: Anthem 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 Certificate of Insurance or Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.

Covered Medical Benefits	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.*	$3,000 person / $6,000 family	$9,000 person / $18,000 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.*	$5,000 person / $10,000 family	$15,000 person / $30,000 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	50% coinsurance after deductible is met
Doctor Home and Office Services		
Primary care visit to treat an injury or illness *All office visit copayments count towards the same 3 visit limit.*	$35 copay per visit for the first 3 visits and then 30% coinsurance after deductible is met	50% coinsurance after deductible is met
Specialist care visit *All office visit copayments count towards the same 3 visit limit.*	$35 copay per visit for the first 3 visits and then 30% coinsurance after deductible is met	50% coinsurance after deductible is met
Prenatal and Post-natal Care	30% coinsurance after deductible is met	50% coinsurance after deductible is met

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Other practitioner visits:		
Retail health clinic *All office visit copayments count towards the same 3 visit limit.*	$35 copay per visit for the first 3 visits and then 30% coinsurance after deductible is met	50% coinsurance after deductible is met
On-line Visit *All office visit copayments count towards the same 3 visit limit.*	$35 copay per visit for the first 3 visits and then 30% coinsurance after deductible is met	50% coinsurance after deductible is met
Chiropractic services *Coverage for In-Network Provider is limited to 20 visit limit per benefit period.*	$30 copay per visit for the first 3 visits and then 30% coinsurance after deductible is met	Not covered
Acupuncture *Coverage for In-Network Provider is limited to 20 visit limit per benefit period. Limited to 20 combined visits for Acupuncture and Massage Therapy.*	$30 copay per visit for the first 3 visits and then 30% coinsurance after deductible is met	Not covered
Other services in an office:		
Allergy testing	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Chemo/radiation therapy	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Hemodialysis	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Prescription drugs *For the drugs itself dispensed in the office thru infusion/injection*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Diagnostic Services		

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Lab:		
Office	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Lab	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
X-ray:		
Office	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency and Urgent Care		
Emergency room facility services	30% coinsurance after deductible is	30% coinsurance after deductible is

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
	met	met
Emergency room doctor and other services	30% coinsurance after deductible is met	30% coinsurance after deductible is met
Ambulance (air and ground)	30% coinsurance after deductible is met	30% coinsurance after deductible is met
Urgent Care (office setting)	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit *All office visit copayments count towards the same 3 visit limit.*	$35 copay per visit for the first 3 visits and then 30% coinsurance after deductible is met	50% coinsurance after deductible is met
Facility visit:		
Facility fees	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and other services	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Surgery		
Facility fees:		
Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and other services		

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)		
Facility fees (for example, room & board) *Coverage for Inpatient physical medicine and rehabilitation including day rehabilitation programs In-Network Provider and Non-Network Provider combined is limited to 60 days per benefit period.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and other services	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Recovery & Rehabilitation		
Home health care *Coverage for In-Network and Non-Network Provider combined is limited to 28 hours per week.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for Occupational Therapy is limited to 20 visits per benefit period, Physical Therapy is limited to 20 visits per benefit period, and Speech Therapy is limited to 20 visits per benefit period. Apply to In-Network Provider and Non-Network Provider combined. All office visit copayments count towards the same 3 visit limit.*	$35 copay per visit for the first 3 visits and then 30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient hospital *Coverage for Occupational Therapy is limited to 20 visits per benefit period, Physical Therapy is limited to 20 visits per benefit period, and Speech Therapy is limited to 20 visits per benefit period. Apply to In-Network Provider and Non-Network Provider combined.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Habilitation services (for example, physical/speech/occupational therapy):		

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Office *Coverage for Occupational Therapy is limited to 20 visits per benefit period, Physical Therapy is limited to 20 visits per benefit period, and Speech Therapy is limited to 20 visits per benefit period. Apply to In-Network Provider and Non-Network Provider combined. All office visit copayments count towards the same 3 visit limit.*	$35 copay per visit for the first 3 visits and then 30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient hospital *Coverage for Occupational Therapy is limited to 20 visits per benefit period, Physical Therapy is limited to 20 visits per benefit period, and Speech Therapy is limited to 20 visits per benefit period. Apply to In-Network Provider and Non-Network Provider combined.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation		
Office *All office visit copayments count towards the same 3 visit limit.*	$35 copay per visit for the first 3 visits and then 30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled nursing care (in a facility) *Coverage for In-Network Provider and Non-Network Provider combined is limited to 100 days per benefit period.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospice	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment *Coverage for hearing aids services In-Network Provider and Non-Network Provider combined is limited to 1 unit every 5 years.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices	30% 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 Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible ***Additional deductible:*** *Applies to Tier 2, Tier 3 and Tier 4 Prescription Drugs for In-Network and Non-Network Provider combined.*	$250 person / $500 family	$250 person / $500 family
Pharmacy Out of Pocket	Combined with medical out of pocket	Combined with medical out of pocket
Prescription Drug Coverage *Anthem Select Drug List*		
Tier 1a - Typically Lower Cost Generic *You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Covers up to a 90 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).*	$0 copay per prescription (retail and home delivery)	50% coinsurance (retail only)
Tier 1b - Typically Generic *Covers up to a 90 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).*	$20 copay per prescription (retail only) and $50 copay per prescription (home delivery only)	50% coinsurance (retail only)
Tier 2 - Typically Preferred Brand & Non-Preferred Generics *Covers up to a 90 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).*	$40 copay per prescription after pharmacy deductible is met (retail only) and $120 copay per prescription after pharmacy deductible is met (home delivery only)	50% coinsurance after pharmacy deductible is met (retail only)
Tier 3 - Typically Non-Preferred Brand *Covers up to a 90 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).*	$80 copay per prescription after pharmacy deductible is met (retail only) and $240 copay per prescription after pharmacy deductible	50% coinsurance after pharmacy deductible is met (retail only)

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
	is met (home delivery only)	
Tier 4 - Typically Specialty (brand and generic) *Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program).*	$375 copay per prescription after pharmacy deductible is met (retail and home delivery)	50% coinsurance after pharmacy deductible is met (retail only)

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. 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		
Child Vision Deductible	Not Applicable	Not Applicable
Vision exam *Coverage for In-Network Provider and Non-Network Provider combined is limited to 1 exam per benefit period.*	No charge	No charge
Frames *Coverage for In-Network Provider and Non-Network Provider combined is limited to 1 unit every 2 years. Coverage for Non-Network Providers is limited to $45 maximum benefit per occurrence.*	No charge	No charge
Lenses *Coverage for In-Network Provider and Non-Network Provider combined is limited to 1 unit every 2 years. Coverage for single vision lenses is limited to $25 maximum benefit per occurrence, bifocal lenses is limited to $40 maximum benefit per occurrence, and trifocal lenses is limited to $55 maximum benefit per occurrence. Apply to Non-Network Providers.*	$20 copay per unit	No charge
Elective contact lenses *Coverage for In-Network Provider and Non-Network Provider combined is limited to 1 unit every 2 years. Coverage for Non-Network Providers is limited to $60 maximum benefit per occurrence.*	No charge	No charge
Non-Elective Contact Lenses *Coverage for In-Network Provider and Non-Network Provider combined is limited to 1 unit every 2 years. Coverage for Non-Network Providers is limited to $210 maximum benefit per occurrence.*	No charge	No charge
Adult Vision		
Adult Vision Deductible	Not Applicable	Not Applicable
Vision exam *Coverage for In-Network Provider and Non-Network Provider combined is limited to 1 exam per benefit period. Coverage for Non-Network Providers is limited to $30 maximum benefit per visit.*	$20 copay per visit	No charge

Your summary of benefits

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Frames *Coverage for In-Network Provider and Non-Network Provider combined is limited to 1 unit every 2 years. Coverage for In-Network Providers is limited to $130 maximum benefit per occurrence. Coverage for Non-Network Providers is limited to $45 maximum benefit per occurrence.*	No charge	No charge
Lenses *Coverage for Eye Glasses or Contact Lens In-Network Provider and Non-Network Provider combined is limited to 1 unit every 2 years, single vision lenses Non-Network Providers is limited to $25 maximum benefit per occurrence, bifocal lenses Non-Network Providers is limited to $40 maximum benefit per occurrence, and trifocal lenses Non-Network Providers is limited to $55 maximum benefit per occurrence.*	$20 copay per unit	No charge
Elective contact lenses *Coverage for In-Network Providers is limited to $80 maximum benefit per occurrence. Coverage for Non-Network Providers is limited to $60 maximum benefit per occurrence. Coverage for Eye Glasses or Contact Lens In-Network Provider and Non-Network Provider combined is limited to 1 unit every 2 years.*	No charge	No charge
Non-Elective Contact Lenses *Coverage for Non-Network Providers is limited to $210 maximum benefit per occurrence. Coverage for Eye Glasses or Contact Lens In-Network Provider and Non-Network Provider combined is limited to 1 unit every 2 years.*	No charge	No charge

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 Provider and Non-Network Provider combined is limited to 2 visits per 12 months.*	No charge	30% coinsurance
Basic services	50% coinsurance	50% coinsurance
Major services	50% coinsurance	50% coinsurance
Medical Necessary Orthodontia services	50% coinsurance	50% coinsurance
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	$0	$0
Annual maximum	$0	$0

Your summary of benefits

Notes:

- Your coinsurance and deductible count toward your out of pocket amount
- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to 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.
- For additional information on this plan, please visit sbc.anthem.com to obtain a "Summary of Benefit Coverage".
- All medical services subject to a coinsurance are also subject to the annual medical deductible.
- If your plan includes a hospital stay copay and you are readmitted within 72 hours of a prior admission for the same diagnosis, your hospital stay copay for your readmission is waived.
- Your copays, coinsurance and deductible count toward your out of pocket amount.
- Your plan requires a selection of a Primary Care Physician.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- 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 providers charge.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.

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