Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your 2022 Contract Code: 6BCQ

Your Plan: Anthem Bronze Guided Access HMO 6900/0%/7000 w/HSA WH

Your Network: HMO

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 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.*	$6,900 person / $13,800 family	Not covered
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	Not covered
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	Not covered
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	Not covered
Virtual Care (Telemedicine / Telehealth Visits)		
Virtual Visits with Doctors who also provide services in person		
Primary Care (PCP)	0% coinsurance after deductible is met	Not covered
Mental Health and Substance Abuse care	0% coinsurance after deductible is met	Not covered

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Specialist	0% coinsurance after deductible is met	Not covered
Medical Chats and Virtual (Video) Visits for Primary Care *from our Online Provider K Health, through its affiliated Provider groups.*	0% coinsurance after deductible is met	Not covered
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	0% coinsurance after deductible is met	Not covered
Specialist Care	0% coinsurance after deductible is met	Not covered
Visits in an Office		
Primary Care (PCP)	0% coinsurance after deductible is met	Not covered
Specialist Care	0% coinsurance after deductible is met	Not covered
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal) *In-Network preventive prenatal services are covered at 100%.*	0% coinsurance after deductible is met	Not covered
Retail Health Clinic	0% coinsurance after deductible is met	Not covered
Spinal Manipulation *Coverage is limited to 50 visits per benefit period. Limit is combined across all settings.*	0% coinsurance after deductible is met	Not covered
Acupuncture	Not covered	Not covered
Other Services in an Office		
Allergy Testing	0% coinsurance after deductible is met	Not covered

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Chemo/Radiation Therapy	0% coinsurance after deductible is met	Not covered
Dialysis/Hemodialysis	0% coinsurance after deductible is met	Not covered
Prescription Drugs - Dispensed in the office *For the drugs itself dispensed in the office through infusion/injection.*	0% coinsurance after deductible is met	Not covered
Surgery	0% coinsurance after deductible is met	Not covered
Diagnostic Services		
Lab		
Office	0% coinsurance after deductible is met	Not covered
Freestanding Lab/Reference Lab	0% coinsurance after deductible is met	Not covered
Outpatient Hospital	0% coinsurance after deductible is met	Not covered
X-Ray		
Office	0% coinsurance after deductible is met	Not covered
Freestanding Radiology Center	0% coinsurance after deductible is met	Not covered
Outpatient Hospital	0% coinsurance after deductible is met	Not covered
Advanced Diagnostic Imaging - for example: MRI, PET and CAT scans		

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Office	0% coinsurance after deductible is met	Not covered
Freestanding Radiology Center	0% coinsurance after deductible is met	Not covered
Outpatient Hospital	0% coinsurance after deductible is met	Not covered
Emergency and Urgent Care		
Urgent Care (Office Setting)	0% coinsurance after deductible is met	Not covered
Emergency Room Facility Services	0% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	0% 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.*	0% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse		
Doctor Office Visit	0% coinsurance after deductible is met	Not covered
Facility visit		
Facility Fees	0% coinsurance after deductible is met	Not covered
Doctor Services	0% coinsurance after deductible is met	Not covered

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Surgery		
Facility Fees		
Hospital	0% coinsurance after deductible is met	Not covered
Freestanding Surgical Center	0% coinsurance after deductible is met	Not covered
Doctor and Other Services		
Hospital	0% coinsurance after deductible is met	Not covered
Freestanding Surgical Center	0% coinsurance after deductible is met	Not covered
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. Applies to In-Network.*	0% coinsurance after deductible is met	Not covered
Doctor and other services	0% coinsurance after deductible is met	Not covered

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Recovery & Rehabilitation		
Home Health Care	0% coinsurance after deductible is met	Not covered
Rehabilitation 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. Applies to In-Network. Limit is combined across all settings.*		
Office	0% coinsurance after deductible is met	Not covered
Outpatient Hospital	0% coinsurance after deductible is met	Not covered
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. Applies to In-Network. Limit is combined across all settings.*		
Office	0% coinsurance after deductible is met	Not covered
Outpatient Hospital	0% coinsurance after deductible is met	Not covered
Cardiac rehabilitation		
Office	0% coinsurance after deductible is met	Not covered
Outpatient Hospital	0% coinsurance after deductible is met	Not covered
Pulmonary rehabilitation		

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Office	0% coinsurance after deductible is met	Not covered
Outpatient Hospital	0% coinsurance after deductible is met	Not covered
Skilled Nursing Care (in a facility) *Coverage is limited to 150 days per benefit period. Applies to In-Network. Limit is combined across a skilled nursing facility and an outpatient day rehabilitation program.*	0% coinsurance after deductible is met	Not covered
Inpatient Hospice	0% coinsurance after deductible is met	Not covered
Durable Medical Equipment	50% coinsurance after deductible is met	Not covered
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period. Applies to In-Network. Coverage for hearing aids services is limited to 1 item per ear every 3 years. Applies to In-Network. Limit is combined across all settings.*	50% coinsurance after deductible is met	Not covered

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 medical deductible	Not covered
Pharmacy Out of Pocket	Combined with In-Network medical out-of-pocket limit	Not covered
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 medication 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).*	0% coinsurance after deductible is met (retail and home delivery)	Not covered (retail and home delivery)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	0% coinsurance after deductible is met (retail and home delivery)	Not covered (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	0% coinsurance after deductible is met (retail and home delivery)	Not covered (retail and home delivery)
Tier 4 - Typically Specialty (brand and generic) *Per 30 day supply (specialty pharmacy).*	0% coinsurance after deductible is met (retail and home delivery)	Not covered (retail and 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 *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit every 2 benefit periods.*	$130 Allowance	Reimbursed Up to $45
Single Vision Lenses *Coverage for Eye Glass Lenses or Contact Lens In-Network Providers and Non-Network Providers is limited to 1 unit every 2 benefit periods.*	$20 copay	Reimbursed Up to $25
Bifocal Vision Lenses *Coverage for Eye Glass Lenses or Contact Lens In-Network Providers and Non-Network Providers is limited to 1 unit every 2 benefit periods.*	$20 copay	Reimbursed Up to $40
Trifocal Vision Lenses *Coverage for Eye Glass Lenses or Contact Lens In-Network Providers and Non-Network Providers is limited to 1 unit every 2 benefit periods.*	$20 copay	Reimbursed Up to $55
Elective contact lenses *Coverage for Eye Glass Lenses or Contact Lens In-Network Providers and Non-Network Providers is limited to 1 unit every 2 benefit periods.*	$80 Allowance	Reimbursed Up to $60
Non-Elective Contact Lenses *Coverage for Eye Glass Lenses or Contact Lens In-Network Providers and Non-Network Providers is limited to 1 unit every 2 benefit periods.*	No charge	Reimbursed Up to $210

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	No charge
Basic services	20% coinsurance after dental deductible is met	20% coinsurance after dental deductible is met
Major services	50% coinsurance after dental deductible is met	50% coinsurance after dental deductible is met
Medically Necessary Orthodontia services	50% coinsurance after dental deductible is met	50% coinsurance after dental deductible is met
Cosmetic Orthodontia services	Not covered	Not covered
Deductible	$50	$50
Adult Dental		
Diagnostic and preventive *Coverage for In-Network Providers and Non-Network Providers is limited to 2 visits per 12 months.*	No charge	No charge
Basic services	20% coinsurance after dental deductible is met	20% coinsurance after dental deductible is met
Major services	50% coinsurance after dental deductible is met	50% coinsurance after dental deductible is met
Deductible	$50	$50

Your summary of benefits

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Annual maximum	$1,000	$1,000

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.
- Your plan requires the selection of 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.
- Additionally, a referral from your Primary Care Physician (PCP) is required for Specialist care and most other providers for select covered services.
- 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.

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:

Chinese(中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(855) 330-1218。

Farsi (فارسي) : در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره 330-1218 (855) تماس بگیرید.

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (855) 330-1218.

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Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(855) 330-1218로 문의하십시오.

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.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: (855) 330-1218.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (855) 330-1218 ਤੇ ਕਾਲ ਕਰੋ।

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It's important we treat you fairly
That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.