Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your 2025 Contract Code: 88A8

Your Plan: Anthem Link Silver Guided Access HMO 4000/6500 w/HSA

Your Network: HMO

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. Unless stated otherwise, services received in an office, Ambulatory Surgical Center, or outpatient facility are combined across all outpatient settings. 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 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 Evidence of Coverage (EOC), will prevail.

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge after deductible is met
Mental Health & Substance Use Disorder Services	No charge after deductible is met
Specialist care	No charge after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	$4,000 person / $8,000 family	Not covered
Overall 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.*	$6,500 person / $13,000 family	Not covered
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per member deductible and per member out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per member deductible or per member out-of-pocket limit. *All medical services subject to a coinsurance are also subject to the annual medical deductible.* *Your copays, coinsurance and deductible count toward your out-of-pocket limit. However, member cost sharing for the following service(s) do not apply toward the out-of-pocket limit: adult vision.*		
Doctor Visits (virtual and office) *Your plan requires the selection of a Primary Care Physician (PCP). A referral from your Primary Care Physician (PCP) is required for Specialist care and most other providers for select covered services.*		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Primary Care (PCP) and Mental Health and Substance Use Disorder Services *virtual and office*	**virtual-**No charge after deductible is met **office-**$50 copay per visit after deductible is met	Not covered
Specialist Care *virtual and office*	**virtual-**No charge after deductible is met **office-**$75 copay per visit after deductible is met	Not covered
Other Practitioner Visits		
Maternity Doctor services (prenatal/postnatal care and delivery) *In-Network preventive prenatal services are covered at 100%.*	$500 copay per pregnancy after deductible is met	Not covered
Retail Health Clinic	$50 copay per visit after deductible is met	Not covered
Spinal Manipulation *Coverage is limited to 50 visits per benefit period.*	$50 copay per visit after deductible is met	Not covered
Acupuncture	Not covered	Not covered
Other Services in an Office		
Allergy Testing	$75 copay per visit after deductible is met‡	Not covered
Prescription Drugs - Dispensed in the office *For the drugs itself dispensed in the office through infusion/injection.*	$500 copay per visit after deductible is met	Not covered
Surgery	$75 copay per visit after deductible is met‡	Not covered
Preventive care/screenings/immunizations	No charge	Not covered
Preventive care for Chronic Conditions *per IRS guidelines*	No charge	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Diagnostic Services		
Lab		
Office	$75 copay per visit after deductible is met‡	Not covered
Freestanding Lab/Reference Lab	No charge after deductible is met	Not covered
Outpatient Hospital	$75 copay per visit after deductible is met	Not covered
X-Ray		
Office	$75 copay per visit after deductible is met‡	Not covered
Freestanding Radiology Center	$60 copay per visit after deductible is met	Not covered
Outpatient Hospital	$75 copay per visit after deductible is met	Not covered
Advanced Diagnostic Imaging - for example: MRI, PET and CAT scans		
Office	$250 copay per visit after deductible is met	Not covered
Freestanding Radiology Center	$250 copay per visit after deductible is met	Not covered
Outpatient Hospital	$500 copay per visit after deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<u>**Emergency and Urgent Care**</u>		
Urgent Care (Office Setting)	$65 copay per visit after deductible is met	Covered as In-Network
Emergency Room Facility Services *Your copay will be waived if admitted.*	$1,000 copay per visit after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	No charge after deductible is met	Covered as In-Network
Ambulance (Air and Ground) *Authorized Out-of-Network non-emergency ambulance services are limited to an Anthem maximum payment of $50,000 per trip.*	$1,000 copay per trip after deductible is met	Covered as In-Network
<u>**Outpatient Mental Health and Substance Use Disorder Services at a Facility**</u>		
Facility Fees	$500 copay per visit after deductible is met	Not covered
Doctor Services	No charge after deductible is met	Not covered
<u>**Outpatient Surgery**</u>		
Facility Fees		
Hospital	$500 copay per visit after deductible is met	Not covered
Ambulatory Surgical Center	$350 copay per visit after deductible is met	Not covered
Physician and other services including surgeon fees		
Hospital	No charge after deductible is met	Not covered
Ambulatory Surgical Center	No charge after deductible is met	Not covered
<u>**Hospital Stay (all Inpatient stays including Maternity, Mental Health and Substance Use Disorder Services)**</u> *If readmitted within 72 hours for the same condition, no additional facility copay is required. If transferred between facilities, only one copay will apply.*		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Facility fees (for example, room & board) *Coverage for Inpatient Rehabilitation is limited to 120 days per benefit period.*	$750 copay per admission after deductible is met	Not covered
Physician and other services including surgeon fees	No charge after deductible is met	Not covered
Home Health Care	$75 copay per visit 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.*		
Office	$75 copay per visit after deductible is met	Not covered
Outpatient Hospital	$75 copay per visit 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.*		
Office	$75 copay per visit after deductible is met	Not covered
Outpatient Hospital	$75 copay per visit after deductible is met	Not covered
Pulmonary rehabilitation office and outpatient hospital	$75 copay per visit after deductible is met	Not covered
Cardiac rehabilitation office and outpatient hospital	$75 copay per visit after deductible is met	Not covered
Dialysis/Hemodialysis		
Office	$75 copay per visit after deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Hospital	$500 copay per visit after deductible is met	Not covered
Chemo/Radiation Therapy		
Office	$75 copay per visit after deductible is met	Not covered
Outpatient Hospital	$500 copay per visit after deductible is met	Not covered
Skilled Nursing Care (in a facility) *Coverage is limited to 150 days per benefit period. Limit is combined across a skilled nursing facility and an outpatient day rehabilitation program.*	$750 copay per admission after deductible is met	Not covered
Inpatient Hospice	$750 copay per admission after deductible is met	Not covered
Durable Medical Equipment	$300 copay per visit after deductible is met	Not covered
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period. Coverage for hearing aids and services is limited to 1 item per ear every 3 years.*	$500 copay per item after deductible is met	Not covered

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with In-Network medical deductible	Not covered
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with In-Network medical out-of-pocket limit	Not covered
Prescription Drug Coverage **Network: *Rx Choice Tiered Network*** **Drug List: *Select*** *Drugs not included on the Select drug list will not be covered. Prescription Drugs that we are required to cover by federal law under the "Preventive Care" benefit will be covered with no deductible, copayments or coinsurance when you use an In-Network Pharmacy.*			
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (cost shares noted below)* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy. You may get two 30-day supply fills of the same maintenance medication at a retail pharmacy. Prior to your 3rd fill, you must call us on the number on your ID card and tell us if you would like to keep getting your maintenance medications from a retail pharmacy or if you would like to use home delivery. If you do not contact us, you will pay the full retail cost of any maintenance medication until you inform us of your decision.* **Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.*			
Preventive Drugs *The deductible does not apply to prescription drugs on the PreventiveRx Plus drug list when you use a Preferred Network or an In-Network Pharmacy.*			
Tier 1 - Typically Generic *Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies.*	$10 copay per prescription after deductible is met (retail) and $25 copay per prescription after deductible is met (home delivery)	$20 copay per prescription after deductible is met (retail only)	Not covered (retail and home delivery)
Tier 2 - Typically Preferred Brand *Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies.*	$60 copay per prescription after deductible is met (retail) and $150 copay per prescription after deductible is met (home delivery)	$70 copay per prescription after deductible is met (retail only)	Not covered (retail and home delivery)

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Tier 3 - Typically Non-Preferred Brand *Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies.*	$125 copay per prescription after deductible is met (retail) and $313 copay per prescription after deductible is met (home delivery)	$145 copay per prescription after deductible is met (retail only)	Not covered (retail and home delivery)
Tier 4 - Typically Specialty (brand and generic)	$500 copay per prescription after deductible is met (retail and home delivery)	$600 copay per prescription after deductible is met (retail only)	Not covered (retail and home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-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 is limited to 1 exam per benefit period.*	No charge	Not covered
Frames *Coverage for In-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Single Vision Lenses *Coverage for In-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Bifocal Vision Lenses *Coverage for In-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Trifocal Vision Lenses *Coverage for In-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Elective contact lenses *Coverage for In-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Non-Elective Contact Lenses *Coverage for In-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Adult Vision (age 19 and older)		
Adult Vision Deductible	Not applicable	Not applicable
Vision exam *Coverage for In-Network Providers is limited to 1 exam per benefit period.*	$20 copay	Not covered
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

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-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 is limited to 2 visits per 12 months.*	No charge	Not covered
Basic services	40% coinsurance after deductible is met	Not covered
Major services	50% coinsurance after deductible is met	Not covered
Medically Necessary Orthodontia services	50% coinsurance after deductible is met	Not covered
Cosmetic Orthodontia services	Not covered	Not covered
Deductible	Combined with medical deductible	Not covered
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

Healthy Support & Rewards

To see your rewards and additional information log into the Anthem website at anthem.com or call the customer service number on your member ID card.

Program Name	Program Description	Program Incentive
Smart Rewards (Wellbeing Solutions Engagement Package 200)	Subscriber and spouse/domestic partner may earn rewards when eligible activities are completed and, in some instances, are verified by an Anthem claim.	Up to $200 per member per year

Notes:

- Benefit period refers to calendar year.
- For additional information on this plan, please visit www.sbc.anthem.com to obtain a "Summary of Benefits and Coverage".
- When you receive services from an Out-of-Network Provider and your plan includes Out-of-Network benefits, you may be required to pay (i) the difference between any amount the plan plays and the provider charges for services (balance billing) in addition to (ii) any applicable copayments, co-insurance, and/or deductibles. This does not apply when you receive emergency services or as otherwise required by law; in such cases, you will only be responsible for any applicable copayments, co-insurance, and/or deductibles.
- To get benefits under this Plan, you must get Covered Services from an In-Network Provider. Services from an Out-of-Network Provider are not covered, except for Emergency Care or Authorized Services. Please have your provider contact us if you are not sure if the Out-of-Network care has been approved as an Authorized Service. Please review the "Evidence of Coverage (EOC)" for more details.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
- ‡ You will pay the PCP's office visit copay when services are provided in their office.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.

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(TTY/TDD: 711)

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