# Your summary of benefits

Anthem

Anthem® Blue Cross and Blue Shield

Your 2025 Contract Code: 88AD

Your Plan: Anthem Silver Choice PPO 3500/20%/7500 w/HSA

Your Network: Choice PPO

*This summary of benefits is a brief outline of coverage, designed to help you with the selection process. Unless stated otherwise, the limitations for In- and Out-of-Network services are combined and 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 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.*

| 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** | 20% coinsurance after deductible is met |

| Covered Medical Benefits | Cost if you use a Preferred Network Provider | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|---|
| **Overall Deductible** | $3,500 person / $7,000 family | $6,500 person / $13,000 family | $13,000 person / $26,000 family |
| **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.* | $7,500 person / $15,000 family | $7,500 person / $15,000 family | $15,000 person / $30,000 family |

*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.*

*In-Network and Out-of-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.*

*The deductibles for Preferred Network and In-Network do not cross apply. The out-of-pocket limits for Preferred Network and In-Network cross apply, meaning satisfying one helps satisfy the other.*

*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.*

| Covered Medical Benefits | Cost if you use a Preferred Network Provider | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|---|
| **Doctor Visits (virtual and office)** *You are encouraged to select a Primary Care Physician (PCP).* | | | |
| **Primary Care (PCP) and Mental Health and Substance Use Disorder Services** *virtual and office* | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Specialist Care** *virtual and office* | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Other Practitioner Visits** | | | |
| Maternity Doctor services (prenatal/postnatal care and delivery) *Preferred Network and In-Network preventive prenatal and postnatal services are covered at 100%.* | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Retail Health Clinic | 20% 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.* | 20% 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 | 20% 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.* | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Surgery | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Preventive care/screenings/immunizations** | No charge | No charge | 50% coinsurance after deductible is met |

| Covered Medical Benefits | Cost if you use a Preferred Network Provider | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|---|
| **Preventive care for Chronic Conditions** *per IRS guidelines* | No charge | No charge | 50% coinsurance after deductible is met |
| **Diagnostic Services** | | | |
| **Lab** | | | |
| Office | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Freestanding Lab/Reference Lab | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Outpatient Hospital | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **X-Ray** | | | |
| Office | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Freestanding Radiology Center | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Outpatient Hospital | 20% 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 | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Freestanding Radiology Center | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Outpatient Hospital | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |

| Covered Medical Benefits | Cost if you use a Preferred Network Provider | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|---|
| **Emergency and Urgent Care** | | | |
| **Urgent Care (Office Setting)** | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Emergency Room Facility Services** | 20% coinsurance after deductible is met | 20% coinsurance after deductible is met | Same as In-Network Tier 1 |
| **Emergency Room Doctor and Other Services** | 20% coinsurance after deductible is met | 20% coinsurance after deductible is met | Same as In-Network Tier 1 |
| **Ambulance (Air and Ground)** *Authorized Out-of-Network non-emergency ambulance services are limited to an Anthem maximum payment of $50,000 per trip.* | 20% coinsurance after deductible is met | 20% coinsurance after deductible is met | Same as In-Network Tier 1 |
| **Outpatient Mental Health and Substance Use Disorder Services at a Facility** | | | |
| Facility Fees | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Doctor Services | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Outpatient Surgery** | | | |
| **Facility Fees** | | | |
| Hospital | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Ambulatory Surgical Center | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Physician and other services including surgeon fees** | | | |
| Hospital | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Ambulatory Surgical Center | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |

| Covered Medical Benefits | Cost if you use a Preferred Network Provider | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|---|
| **Hospital Stay (all Inpatient stays including Maternity, Mental Health and Substance Use Disorder Services)** | | | |
| **Facility fees (for example, room & board)** *Coverage for Inpatient Rehabilitation is limited to 120 days per benefit period.* | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Physician and other services including surgeon fees** | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Home Health Care** | 20% 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)** *Coverage for physical therapy, occupational therapy and speech therapy is limited to 120 visits combined per benefit period.* | | | |
| Office | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Outpatient Hospital | 20% 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.* | | | |
| Office | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Outpatient Hospital | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Pulmonary rehabilitation** office and outpatient hospital | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Cardiac rehabilitation** office and outpatient hospital | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |

| Covered Medical Benefits | Cost if you use a Preferred Network Provider | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|---|
| **Dialysis/Hemodialysis** office and outpatient hospital | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Chemo/Radiation Therapy** office and outpatient hospital | 20% 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 across a skilled nursing facility and an outpatient day rehabilitation program.* | 20% 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. Coverage for hearing aids and services is limited to 1 item per ear every 3 years.* | 50% coinsurance after deductible is met | 50% coinsurance after deductible is met | 50% coinsurance after deductible is met |

| 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 Preferred Network medical deductible | Combined with Preferred Network medical deductible | Combined with Out-of-Network medical deductible |
| **Pharmacy Out-of-Pocket Limit** | Combined with Preferred Network medical out-of-pocket limit | Combined with Preferred Network medical out-of-pocket limit | Combined with Out-of-Network medical out-of-pocket limit |
| **Prescription Drug Coverage**<br>**Network:** ***Rx Choice Tiered Network***<br>**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:**<br>**Retail Pharmacy** *30 day supply (cost shares noted below)*<br>**Retail 90 Pharmacy** *90 day supply (cost shares noted below)*<br>**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.*<br>**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**<br>*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** | 25% coinsurance after deductible is met (retail and home delivery) | 35% coinsurance after deductible is met (retail only) | 50% coinsurance after deductible is met (retail) and Not covered (home delivery) |
| **Tier 2 - Typically Preferred Brand** | 25% coinsurance after deductible is met (retail and home delivery) | 35% coinsurance after deductible is met (retail only) | 50% coinsurance after deductible is met (retail) and Not covered (home delivery) |
| **Tier 3 - Typically Non-Preferred Brand** | 25% coinsurance after deductible is met (retail and home delivery) | 35% coinsurance after deductible is met (retail only) | 50% coinsurance after deductible is met (retail) and Not |

| 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 |
|---|---|---|---|
| | | | covered (home delivery) |
| **Tier 4 - Typically Specialty (brand and generic)** | 25% coinsurance after deductible is met (retail and home delivery) | 35% coinsurance after deductible is met (retail only) | 50% coinsurance after deductible is met (retail) and Not covered (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**<br>*Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 exam per benefit period.* | No charge | Not covered |
| **Frames**<br>*Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.* | No charge | Not covered |
| **Single Vision Lenses**<br>*Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.* | No charge | Not covered |
| **Bifocal Vision Lenses**<br>*Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.* | No charge | Not covered |
| **Trifocal Vision Lenses**<br>*Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.* | No charge | Not covered |
| **Elective contact lenses**<br>*Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit per benefit period.* | No charge | Not covered |
| **Non-Elective Contact Lenses**<br>*Coverage for In-Network Providers and Out-of-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**<br>*Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 exam per benefit period.* | $20 copay | Reimbursed Up to $30 |
| **Frames** | Not covered | Not covered |
| **Single Vision Lenses** | Not covered | Not covered |

| Covered Vision Benefits | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|
| **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**<br>*Coverage for In-Network Providers and Out-of-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 |

**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 the highest benefits at the lowest Out-of-Pocket cost, you must get Covered Services from an In-Network Provider. Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service. Except for emergency services received or as otherwise required by law, when you use an Out-of-Network Provider you may have to pay the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. This amount can be substantial. 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.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.



Questions: (855) 330-1218 or visit us at www.anthem.com

NV/SG/Anthem Silver Choice PPO 3500/20%/7500 w/HSA/88AD/01-01-2025

## 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 (855) 330-1218 .

**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。

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**Italian (Italiano):** In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (855) 330-1218.

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## Language Access Services:

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**Navajo (Diné):** Díí naaltsoos biká'ígíí łahgo bina'ídiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ąh ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínízingo kojį' hodíílnih (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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**Vietnamese (Tiếng Việt):** Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (855) 330-1218.

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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.