Your summary of benefits

Anthem

Anthem® Blue Cross and Blue Shield

Your 2025 Contract Code: 8P45

Your Plan: Anthem Silver Blue Access Choice 3800EC/0%/7900 w/HSA

Your Network: Blue Access Choice

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 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	$75 copay per visit 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	$3,800 person / $7,600 family	$9,500 person / $19,000 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.*	$7,900 person / $15,800 family	$19,750 person / $39,500 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.*		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP). For members up to age 19, visits in an office with In-Network Providers for primary care, and mental health and substance use disorder services are covered at no charge after deductible is met.*		
Primary Care (PCP) and Mental Health and Substance Use Disorder Services *virtual and office*	$35 copay per visit after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Specialist Care *virtual and office*	$75 copay per visit after deductible is met	30% coinsurance after deductible is met
Other Practitioner Visits		
Maternity Doctor services (prenatal/postnatal care and delivery) *In-Network preventive prenatal services are covered at 100%.*	No charge after deductible is met	30% coinsurance after deductible is met
Retail Health Clinic	$35 copay per visit after deductible is met	30% coinsurance after deductible is met
Chiropractic Services *Coverage is limited to 26 visits per benefit period. Does not include manipulation by a professional provider other than a chiropractor.*	50% coinsurance after deductible is met	Not covered
Acupuncture	Not covered	Not covered
Other Services in an Office		
Allergy Testing	No charge after deductible is met	30% coinsurance after deductible is met
Prescription Drugs - Dispensed in the office *For the drugs itself dispensed in the office through infusion/injection.*	No charge after deductible is met	50% coinsurance after deductible is met
Surgery	$75 copay per surgery after deductible is met	30% coinsurance after deductible is met
Preventive care / screenings / immunizations *Immunizations for children prior to their 6th birthday have No Cost Share for In-Network and Out-of-Network Charges. This applies to childhood immunizations only, not other preventive care.*	No charge	30% coinsurance after deductible is met
Preventive care for Chronic Conditions *per IRS guidelines*	No charge	30% coinsurance after deductible is met
Diagnostic Services		
Lab		
Office	No charge after deductible is met	30% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Hospital	No charge after deductible is met	30% coinsurance after deductible is met
X-Ray		
Office	No charge after deductible is met	30% coinsurance after deductible is met
Freestanding Radiology Center	No charge after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	No charge after deductible is met	30% coinsurance after deductible is met
Advanced Diagnostic Imaging - for example: MRI, PET and CAT scans		
Office	No charge after deductible is met	30% coinsurance after deductible is met
Freestanding Radiology Center	No charge after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	No charge after deductible is met	30% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	$50 copay per visit after deductible is met	30% coinsurance after deductible is met
Emergency Room Facility Services *Your copay will be waived if admitted.*	$400 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
Emergency Room Doctor Services for Mental Health and Substance Use Disorders	$35 copay per visit 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.*	No charge after deductible is met	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	No charge after deductible is met	30% coinsurance after deductible is met
Doctor Services	No charge after deductible is met	30% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	No charge after deductible is met	30% coinsurance after deductible is met
Ambulatory Surgical Center	No charge after deductible is met	30% coinsurance after deductible is met
Physician and other services including surgeon fees		
Hospital	No charge after deductible is met	30% coinsurance after deductible is met
Ambulatory Surgical Center	No charge after deductible is met	30% coinsurance after deductible is met
Hospital Stay (all Inpatient stays including Maternity, Mental Health and Substance Use Disorder Services)		
Facility fees (for example, room & board) *Physical Medicine, Rehab & Skilled Nursing Facility limited to 150 days combined per benefit period.*	No charge after deductible is met	30% coinsurance after deductible is met
Physician and other services including surgeon fees	No charge after deductible is met	30% coinsurance after deductible is met
Home Care Visits *Home health visits are limited to 100 visits per benefit period. Private Duty Nursing included with Home Health Care is limited to 82 visits per benefit period. Benefit limit does not apply to Home Infusion Therapy. Benefit limit and cost share applies to physical, occupational, speech, respiratory, cardiac and pulmonary therapy when performed as part of Home Health.*	No charge after deductible is met	30% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy) *Coverage for rehabilitative and habilitative physical therapy and manipulative treatment is limited to 20 visits combined per benefit period. Coverage for rehabilitative and habilitative occupational therapy is limited to 20 visits combined per benefit period.*		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Office	$35 copay per visit after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	No charge after deductible is met	30% coinsurance after deductible is met
Habitation services (for example, physical/speech/occupational therapy) *Coverage for rehabilitative and habilitative physical therapy and manipulative treatment is limited to 20 visits combined per benefit period. Coverage for rehabilitative and habilitative occupational therapy is limited to 20 visits combined per benefit period.*		
Office	$35 copay per visit after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	No charge after deductible is met	30% coinsurance after deductible is met
Pulmonary rehabilitation office and outpatient hospital	No charge after deductible is met	30% coinsurance after deductible is met
Cardiac rehabilitation office and outpatient hospital *Coverage is limited to 36 visits per benefit period.*	No charge after deductible is met	30% coinsurance after deductible is met
Dialysis/Hemodialysis office and outpatient hospital	No charge after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy office and outpatient hospital	No charge after deductible is met	30% coinsurance after deductible is met
Skilled Nursing Care (in a facility) *Physical Medicine, Rehab & Skilled Nursing Facility limited to 150 days combined per benefit period.*	No charge after deductible is met	30% coinsurance after deductible is met
Inpatient Hospice	No charge after deductible is met	30% coinsurance after deductible is met
Durable Medical Equipment	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices *Coverage for Wigs is limited to one (1) item after cancer treatment per benefit period In-Network Providers and Out-of-Network Providers combined. Coverage for hearing aids services in each ear is limited to 1 unit every 36 months. Newborn hearing aids no limit.*	No charge after deductible is met	30% 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 In-Network medical deductible	Combined with In-Network medical deductible	Combined with Out-of-Network medical deductible
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with In-Network medical out-of-pocket limit	Combined with Out-of-Network medical out-of-pocket limit
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.*	$15 copay per prescription after deductible is met (retail) and $30 copay per prescription after deductible is met (home delivery)	$25 copay per prescription after deductible is met (retail only)	50% coinsurance after deductible is met (retail) and Not covered (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)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
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*	$125 copay per prescription after deductible is met	$135 copay per prescription after	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
share(s) charged at Preferred Network and In-Network Retail Pharmacies.	(retail) and $313 copay per prescription after deductible is met (home delivery)	deductible is met (retail only)	covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	25% coinsurance up to $400 per prescription after deductible is met (retail and home delivery)	25% coinsurance up to $500 per prescription 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 *Coverage for In-Network Providers and Out-of-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 Out-of-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 Out-of-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 Out-of-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 Out-of-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 Out-of-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 Out-of-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 *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
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 and Out-of-Network Providers is limited to 2 visits per 12 months.*	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Basic services	50% 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".
- This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.
- To view your prescription formulary list log on to http://www.anthem.com/pharmacyinformation/
- 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.
- Extent of Coverage of Non-Emergency Care Outside the US is Full Access to the BlueCard network.
- Covered dependents are covered through the end of the month in which the child attains age 26.
- Limitations and Cost shares may vary by site of service. You should refer to your formal contract of coverage for details.
- No Charge means you will not have to pay deductible, copayment and/or coinsurance cost shares up to the maximum allowable amount.
- Primary Care Physician (PCP) is a professional provider who is a practitioner who specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other professional provider as allowed by the plan.
- Specialty Provider (SCP) is a professional provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
- 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.
- Covered accidental dental services are covered up to $3000 per accident for professional services only.
- Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, 3D mammography, breast ultrasounds and MRIs are covered in full after deductible as required by state mandate.
- This health plan includes an Employee Assistance Program (EAP) to support your emotional health and wellness with work life resources, including one-on-one counseling by phone, in person and online. Three counseling visits are available at no charge to a member. EAP member service is accessible 24/7/365.
- Elective Abortion - not covered.

Questions: (855) 330-1101 or visit us at www.anthem.com

MO/SG/Anthem Silver Blue Access Choice 3800EC/0%/7900 w/HSA/8P45/01-01-2025

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document

Spanish
Usted tiene derecho a obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

Chinese
您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID 卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

Vietnamese
Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của tài liệu này.

Korean
귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인이신가요? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

Tagalog
May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

Russian
У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

French Creole
Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòma nan dokiman sa a.

Arabic
لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجانًا. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضًا طلب تنسيقات أخرى لهذه الوثيقة.

French
Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

Persian
شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

Armenian
Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Պարզապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցո՞ղ եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

Japanese
あなたにはあなたの言語で無料で支援を受ける権利があります。ID カードに記載されている会員サービス番号にお電話ください」視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

Italian
Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

German
Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen Formaten anfordern.

Polish
Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

Pennsylvania Dutch
Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kannscht des do Schreiwes in en differnter Weg griege so as du's besser sehne kannscht.

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or directly to 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. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf