

Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Contract Code: 5SCB

Your Plan: Anthem Silver Blue Access 2800E/20%/5600 w/HSA

Your Network: Blue Access

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 <i>See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.</i>	\$2,800 person / \$5,600 family	\$7,000 person / \$14,000 family
Out-of-Pocket Limit <i>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.</i>	\$5,600 person / \$11,200 family	\$14,000 person / \$28,000 family
Preventive care/screening/immunization <i>In-network preventive care is not subject to deductible, if your plan has a deductible. Immunizations for children prior to their 6th birthday have No Cost Share for In-Network and Non-Network Charges. This applies to childhood immunizations only, not other preventive care.</i>	No charge	40% coinsurance after deductible is met
Doctor Home and Office Services Primary Care Office Visit to treat an injury or illness	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Specialist Care Office Visit and Online Visit	20% coinsurance after deductible is met	40% coinsurance after deductible is met

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Prenatal and Post-natal Care <i>In-Network preventive prenatal services are covered at 100%.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Other Practitioner Visits: Medical Chats - <i>within our mobile app</i> Retail Health Clinic On-line Visit <i>Includes Mental/Behavioral Health and Substance Abuse Live Health Online is the preferred telehealth solution. (www.livehealthonline.com).</i> Chiropractic Services <i>Coverage is limited to 26 visits per benefit period. Applies to In-Network. Does not include manipulation by a professional provider other than a chiropractor.</i> Acupuncture	0% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met 50% coinsurance after deductible is met Not covered	Not Applicable 40% coinsurance after deductible is met 40% coinsurance after deductible is met Not covered Not covered
Other Services in an Office: Allergy Testing Chemo/Radiation Therapy Hemodialysis Prescription Drugs <i>For the drugs itself dispensed in the office through infusion/injection.</i>	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met 50% coinsurance after deductible is met

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<p>Diagnostic Services</p> <p>Lab:</p> <ul style="list-style-type: none"> Office Freestanding Lab/Reference Lab Outpatient Hospital 	<ul style="list-style-type: none"> 20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met 	<ul style="list-style-type: none"> 40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met
<p>X-Ray:</p> <ul style="list-style-type: none"> Office Freestanding Radiology Center Outpatient Hospital 	<ul style="list-style-type: none"> 20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met 	<ul style="list-style-type: none"> 40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met
<p>Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):</p> <ul style="list-style-type: none"> Office Freestanding Radiology Center Outpatient Hospital 	<ul style="list-style-type: none"> 20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met 	<ul style="list-style-type: none"> 40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met

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Emergency and Urgent Care Urgent Care	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Emergency Room Facility Services	20% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	Covered as In-Network
Ambulance (Air and Ground)	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse Doctor Office Visit	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Facility visit: Facility Fees	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Surgery Facility Fees: Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Doctor and Other Services:</p> <p>Hospital</p> <p>Freestanding Surgical Center</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p>Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)</p> <p>Facility fees (for example, room & board) <i>Physical Medicine, Rehab & Skilled Nursing Facility limited to 150 days combined per benefit period. Limit is combined In-Network and Non-Network.</i></p> <p>Doctor and other services</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Recovery & Rehabilitation</p> <p>Home Care Visits <i>Coverage is limited to 100 visits per benefit period. Private Duty Nursing included with Home Health Care is limited to 82 visits per benefit period. Limit is combined In-Network and Non-Network. Benefit limit does not apply to Home Infusion Therapy. Limit does not apply to separate Physical or Occupational or Speech Therapy limits, when performed as part of Home Health.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>
<p>Rehabilitation services (for example, physical/speech/occupational therapy):</p> <p>Office <i>Coverage for Occupational Rehabilitation services is limited to 20 visits per benefit period. Coverage for Physical Rehabilitation services is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings. Limit is combined across professional visits and outpatient facilities.</i></p> <p>Outpatient Hospital <i>Coverage for Occupational Rehabilitation services is limited to 20 visits per benefit period. Coverage for Physical Rehabilitation services is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings. Limit is combined across professional visits and outpatient facilities.</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p>Habilitation services (for example, physical/speech/occupational therapy):</p> <p>Office <i>Coverage for Occupational Habilitation services is limited to 20 visits per benefit period. Coverage for Physical Habilitative services is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings. Limit is combined across professional visits and outpatient facilities.</i></p> <p>Outpatient Hospital <i>Coverage for Occupational Habilitation services is limited to 20 visits per benefit period. Coverage for Physical Habilitative services is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings. Limit is combined across professional visits and outpatient facilities.</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Cardiac rehabilitation</p> <p>Office Visit <i>Coverage is limited to 36 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.</i></p> <p>Outpatient Hospital <i>Coverage is limited to 36 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p>Skilled Nursing Care (in a facility) <i>Physical Medicine, Rehab & Skilled Nursing Facility limited to 150 days combined per benefit period. Limit is combined In-Network and Non-Network.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>
<p>Hospice</p>	<p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>
<p>Durable Medical Equipment</p>	<p>50% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p>
<p>Prosthetic Devices <i>Coverage for Wigs after cancer treatment is limited to one (1) per benefit period In-Network Providers and Non-Network Providers combined. Coverage for hearing aids services in each ear is limited to 1 unit every 36 months. Newborn hearing aids no limit. Limit is combined In-Network and Non-Network.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with In-Network medical deductible	Combined with Non-Network medical deductible
Pharmacy Out of Pocket	Combined with In-Network medical out of pocket maximum	Combined with In-Network medical out of pocket maximum	Combined with Non-Network medical out of pocket maximum
Prescription Drug Coverage <i>Select Drug List</i> <i>This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.</i>			
Tier 1 - Typically Generic <i>Covers up to a 90 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.</i>	20% coinsurance after deductible is met (retail and home delivery)	30% coinsurance after deductible is met (retail) and 20% coinsurance after deductible is met (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand <i>Covers up to a 90 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.</i>	20% coinsurance after deductible is met (retail and home delivery)	30% coinsurance after deductible is met (retail) and 20% coinsurance after deductible is met (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand <i>Covers up to a 90 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.</i>	20% coinsurance after deductible is met (retail and home delivery)	30% coinsurance after deductible is met (retail) and 20% coinsurance after deductible is met (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Tier 4 - Typically Specialty (brand and generic) <i>Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program). No coverage for non-formulary drugs.</i></p>	<p>20% coinsurance after deductible is met (retail and home delivery)</p>	<p>30% coinsurance after deductible is met (retail) and 20% coinsurance after deductible is met (home delivery)</p>	<p>50% coinsurance after deductible is met (retail) and Not covered (home delivery)</p>

Your summary of benefits

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><i>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.</i></p> <p><i>Only children's vision services count towards your out of pocket limit.</i></p>		
<p>Children's Vision Essential Health Benefits (up to age 19)</p>		
<p>Child Vision Deductible</p> <p>Vision exam <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.</i></p>	<p>Not Applicable</p> <p>No charge</p>	<p>Not Applicable</p> <p>\$0 copayment up to plan's Maximum Allowed Amount</p>
<p>Frames <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>\$0 copayment up to plan's Maximum Allowed Amount</p>
<p>Single Vision Lenses <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>\$0 copayment up to plan's Maximum Allowed Amount</p>
<p>Bifocal Vision Lenses <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>\$0 copayment up to plan's Maximum Allowed Amount</p>
<p>Trifocal Vision Lenses <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>\$0 copayment up to plan's Maximum Allowed Amount</p>
<p>Elective contact lenses <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>\$0 copayment up to plan's Maximum Allowed Amount</p>
<p>Non-Elective Contact Lenses <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>\$0 copayment up to plan's Maximum Allowed Amount</p>
<p>Adult Vision (age 19 and older)</p> <p>Adult Vision Deductible</p>	<p>Not Applicable</p>	<p>Not Applicable</p>

Your summary of benefits

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Vision exam <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.</i>	\$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

Your summary of benefits

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><i>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.</i></p>		
Children's Dental Essential Health Benefits Diagnostic and preventive <i>Coverage for In-Network Providers and Non-Network Providers is limited to 2 visits per 12 months.</i>	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

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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.
- 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.
- 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.
- Specialty Provider (SCP) is a professional provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
- Primary Care Physician (PCP) is a professional provider who is a practitioner and specializes in either family practice, general practice, internal medicine, pediatrics or geriatrics or is any other professional provider as allowed by the plan.
- If your plan includes out-of-network benefits, In-network and out-of-network deductibles, copayments, coinsurance and out-of-pocket maximum amounts are separate and do not accumulate toward each other.
- Pediatric Dental is embedded in all plans.
- Pediatric Vision & Adult vision exam only – is embedded in all plans.
- If your plan includes out of network benefits, all services with calendar year limits are combined both in and out of network.
- Extent of Coverage of Non-Emergency Care Outside the US is Full Access to the BlueCard network.
- Covered accidental dental services are covered up to \$3000 per accident for professional services only.
- Elective Abortion - not covered.
- No Charge means you will not have to pay deductible, copayment and/or coinsurance cost shares up to the maximum allowable amount.
- 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.
- 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.

In Missouri, (excluding 30 counties in the Kansas City area) Anthem Blue Cross and Blue Shield is the trade name of RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. Independent licensees of the Blue Cross and Blue Shield Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

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

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- If readmitted within 72 hours for the same diagnosis of the previous discharge, no additional facility copayment is required. If transferred between facilities, only one copayment will apply.
- Vision services are not subject to the annual deductible.
- To view your prescription formulary list log on to www.anthem.com/health-insurance/customer-care/forms-library.
- Benefit period refers to calendar year.

In Missouri, (excluding 30 counties in the Kansas City area) Anthem Blue Cross and Blue Shield is the trade name of RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. Independent licensees of the Blue Cross and Blue Shield Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

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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) 330-1101

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) 330-1101.

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) 330-1101:

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Farsi (فارسی): 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 (855) 330-1101 تماس بگیرید.

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Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(855) 330-1101 にお電話ください。

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Language Access Services:

Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'idiikidgo ná bohónéedzǎ dóó bee ahóót'i' t'áá ni nizaad k'ehǫ́ bee nił hodoonih t'áadoo bǫ́áh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih ninizingo kojí' hodíílnih (855) 330-1101.

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) 330-1101.

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