Your summary of benefits

Anthem

Anthem® Blue Cross and Blue Shield

Your Plan: Nye County: Custom Guided Access HMO

Your Network: HMO

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge
Mental Health & Substance Use Disorder Services	No charge
Specialist care	$25 copay per visit

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	$0 member / $0 family	Not covered
Overall Out-of-Pocket Limit	$2,500 member / $5,000 family	Not covered
The family out-of-pocket limit is embedded, meaning each covered person is capped at his or her per member out-of-pocket limit; in addition, cost shares for all covered family members apply to the family out-of-pocket limit, yet no one member will pay more than the per member out-of-pocket limit. All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit.		
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.*		
Primary Care (PCP) and Mental Health and Substance Use Disorder Services *virtual and office*	**virtual-**$15 copay per visit **office-**$25 copay per visit	Not covered
Specialist Care *virtual and office*	**virtual-**$25 copay per visit **office-**$50 copay per visit	Not covered
<u>Other Practitioner Visits</u>		
Maternity Doctor services (prenatal/postnatal care and delivery)	No charge	Not covered
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$25 copay per visit	Not covered
Spinal Manipulation *Coverage is limited to 20 visits per benefit period.*	$25 copay per visit	Not covered
Acupuncture *Coverage is limited to 20 visits per benefit period.*	$25 copay per visit	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Other Services in an Office		
Allergy Testing	$25 copay per visit	Not covered
Prescription Drugs *Dispensed in the office*	No charge	Not covered
Surgery	No charge	Not covered
Preventive care / screenings / immunizations	No charge	Not covered
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	Not covered
Diagnostic Services		
Lab		
Office	No charge	Not covered
Freestanding Lab/Reference Lab	No charge	Not covered
Outpatient Hospital	No charge	Not covered
X-Ray		
Office	$25 copay per visit	Not covered
Freestanding Radiology Center	$25 copay per visit	Not covered
Outpatient Hospital	$25 copay per visit	Not covered
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	$100 copay per service	Not covered
Freestanding Radiology Center	$100 copay per service	Not covered
Outpatient Hospital	$100 copay per service	Not covered
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided. There may be other levels of cost share that are contingent on how services are provided.*	$25 copay per visit	Covered as In-Network
Emergency Room Facility Services *Your copay will be waived if admitted.*	$100 copay per visit	Covered as In-Network
Emergency Room Doctor and Other Services *There may be other levels of cost share that are contingent on how services are provided.*	No charge	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Ambulance	No charge	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	$400 copay per visit	Not covered
Doctor Services	$25 copay per visit	Not covered
Outpatient Surgery		
Facility Fees		
Hospital	$200 copay per surgery	Not covered
Ambulatory Surgical Center	$200 copay per surgery	Not covered
Physician and other services *including surgeon fees*		
Hospital	No charge	Not covered
Ambulatory Surgical Center	No charge	Not covered
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services) *If readmitted within 72 hours for the same condition, no additional facility copay is required. If transferred between facilities, only one copay will apply.*		
Facility Fees	$400 copay per admission	Not covered
Physician and other services *including surgeon fees*	No charge	Not covered
Home Health Care *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	$25 copay per visit	Not covered
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for physical, occupational and speech therapies is limited to 120 visits combined per benefit period. Costs may vary by site of service.* *Office and outpatient visits count towards your rehabilitation limit.*		
Office	$25 copay per visit	Not covered
Outpatient Hospital	$25 copay per visit	Not covered
Pulmonary rehabilitation *office and outpatient hospital*	$25 copay per visit	Not covered
Cardiac rehabilitation *office and outpatient hospital* *Coverage is limited to 36 visits per benefit period.*	$25 copay per visit	Not covered
Dialysis/Hemodialysis		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Office	$25 copay per visit	Not covered
Outpatient Hospital	$500 copay per visit	Not covered
Chemo/Radiation Therapy *office and outpatient hospital*	$25 copay per visit	Not covered
Skilled Nursing Care (facility) *Coverage is limited to 150 days per benefit period.*	$400 copay per admission	Not covered
Inpatient Hospice	$300 copay per admission	Not covered
Durable Medical Equipment	$100 copay per visit	Not covered
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment up to a $500 maximum per member.*	$50 copay per visit	Not covered
Hearing Aids *Coverage is limited to one hearing aid per hearing-impaired ear per 36 months, for adults and children, including wearable and bone anchored hearing aids.*	No charge	Not covered

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible	Not applicable	Not covered
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Not covered
Prescription Drug Coverage **Network:** ***Base Network*** **Drug List:** ***Essential*** *Drugs not included on the Essential drug list will not be covered.*		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).* **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. Drug cost share assistance programs may be available for certain specialty drugs.*		
Tier 1 - Typically Generic	$7 copay per prescription (retail) and	Not covered (retail and home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
	$17.50 copay per prescription (home delivery)	
Tier 2 - Typically Preferred Brand	$30 copay per prescription (retail) and $75 copay per prescription (home delivery)	Not covered (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand	$50 copay per prescription (retail) and $125 copay per prescription (home delivery)	Not covered (retail and home delivery)
Tier 4 - Typically Specialty (brand and generic)	20% coinsurance up to $500 per prescription (retail and home delivery)	Not covered (retail and home delivery)

Notes:

- The Primary Care Physician and Specialist office visit cost share applies to both office and facility based office visits for evaluation and management services only.
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, 3D mammography, breast ultrasounds and MRIs are covered in full as required by state mandate.
- 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.

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.

Questions: (877) 811-3106 or visit us at www.anthem.com

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Your Network: HMO

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date

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