Your summary of benefits

Anthem

Anthem® Blue Cross and Blue Shield

Your 2023 Contract Code: 6SGP

Your Plan: Anthem Gold PPO 1500/20%/6250

Your Network: KeyCare

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 policy has exclusions and limitations to benefits and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact your insurance agent or call us. If there is a difference between this summary of coverage, the Evidence of Coverage (EOC) will prevail.

This benefit summary is not to be distributed without also providing access on limitations and exclusions that apply to our medical plans. Visit https://www.anthemplancomparison.com/va to access this information.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$1,500 person / $3,000 family	$3,750 person / $7,500 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.*	$6,250 person / $12,500 family	$15,625 person / $31,250 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 Non-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.* *Your copays, coinsurance and deductible count toward your out-of-pocket limit. However, member cost sharing for adult vision and Non-Network Human Organ and Tissue Transplant services do not apply toward the out-of-pocket limit.*		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP). Visits in an office with an In-Network Primary Care Provider (PCP) or Preferred Primary Care (PPC) Provider are covered at no charge for members up to age 19.*		
Medical Chats and Virtual Visits for Primary Care *from our Online Provider K Health, through its affiliated Provider groups are covered at No charge.*		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Virtual Visits from online provider LiveHealth Online *for urgent/acute medical and mental health and substance abuse care via www.livehealthonline.com are covered at No charge.*		
Preferred PCP *virtual and office*	$15 copay per visit deductible does not apply	Not covered
Primary Care (PCP) *virtual and office*	$25 copay per visit deductible does not apply	50% coinsurance after deductible is met
Mental Health and Substance Abuse Care *virtual and office*	$25 copay per visit deductible does not apply	50% coinsurance after deductible is met
Specialist Care *virtual and office*	$60 copay per visit deductible does not apply	50% coinsurance after deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal) *In-Network preventive prenatal services are covered at 100%.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Retail Health Clinic	$25 copay per visit deductible does not apply	50% coinsurance after deductible is met
Chiropractic Services *Coverage for rehabilitation and habilitation is limited to 30 visits per benefit period.*	$25 copay per visit deductible does not apply	50% coinsurance after deductible is met
Acupuncture	Not covered	Not covered
Other Services in an Office		
Allergy Testing	$15 copay per visit deductible does not apply	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	50% coinsurance after deductible is met
Surgery	$60 copay per surgery deductible does not apply	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Preventive care/screenings/immunizations *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	50% coinsurance after deductible is met
Preventive care for Chronic Conditions *per IRS guidelines*	No charge	50% coinsurance after deductible is met
Diagnostic Services		
Lab		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Preferred Reference Lab	No charge	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
X-Ray		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	$75 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	20% 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	50% coinsurance after deductible is met
Freestanding Radiology Center	$200 copay per service deductible does not apply	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care Center Office Visit	$60 copay per visit deductible does not apply	50% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$400 copay per visit after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	Covered as In-Network
Emergency Room Mental Health and Substance Abuse Doctor Services	$25 copay per visit after deductible is met	Covered as In-Network
Ambulance Transportation	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse Care at a Facility		
Facility Fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Ambulatory Surgical Center	$300 copay per visit deductible does not apply	50% coinsurance after deductible is met
Doctor and Other Services		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Ambulatory Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospital Stay (all Inpatient stays including Maternity, Mental Health and Substance Abuse)		
Facility fees (for example, room & board) *Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 100 days combined per admission.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Physician and other services including surgeon fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Home Health Care *Coverage is limited to 100 visits per benefit period. Private Duty Nursing included with Home Health Care is limited to 16 hours per benefit period. Visit limit does not apply to Home Infusion Therapy or Home Dialysis.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy) *Coverage for physical therapy and occupational therapy is limited to 30 visits combined per benefit period. Coverage for speech therapy is limited to 30 visits per benefit period. Visit limit does not apply when performed as part of Early Intervention or Hospice. When rendered in the home, the Home Care visit limit applies instead of the Therapy Services limits.*		
Office	$25 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Habilitation services (for example, physical/speech/occupational therapy) *Coverage for physical therapy and occupational therapy is limited to 30 visits combined per benefit period. Coverage for speech therapy is limited to 30 visits per benefit period.*		
Office	$25 copay per visit deductible does not apply	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Pulmonary rehabilitation		
Office	$60 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation		
Office	$60 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Dialysis/Hemodialysis office and outpatient hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Radiation/Chemotherapy/Non Preventive Infusion & Injection office and outpatient hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (in a facility) *Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 100 days combined per admission.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Inpatient Hospice	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out of Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Prescription Drug Coverage **Network:** ***Advantage Network*** **Drug List:** ***Select*** *Drugs not included on the Select drug list will not be covered.*		
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 CarelonRx Mail (IngenioRx will become CarelonRx on January 1, 2023). You will need to call us on the number on your ID card to sign up when you first use the service.* **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.*		
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 In-Network Retail Pharmacies. Coverage is also provided for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time.*	$15 copay per prescription (retail) and $38 copay per prescription (home delivery)	50% coinsurance (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 In-Network Retail Pharmacies. Coverage is also provided for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time.*	$45 copay per prescription (retail) and $135 copay per prescription (home delivery)	50% coinsurance (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 share(s) charged at In-Network Retail Pharmacies. Coverage is also provided for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time.*	25% coinsurance up to $200 per prescription (retail) and 25% coinsurance up to $600 per prescription (home delivery)	50% coinsurance (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) *Coverage is also provided for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time.*	25% coinsurance up to $400 per prescription (retail and home delivery)	50% coinsurance (retail) and Not covered (home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-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 Non-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 Non-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 Non-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 Non-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 Non-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 Non-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 Non-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 Non-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 a Non-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 a Non-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 Non-Network Providers combined is limited to 2 visits per 12 months.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
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

Your plan also includes the following Healthy Support & Rewards features. *To see your rewards and additional information log into the Anthem website at anthem.com or call the customer service number on your member ID card.*		
Smart Rewards (Wellbeing Solutions Engagement Package 200)	Subscriber and spouse/domestic partner may earn rewards when eligible activities are completed and, in some instances, are verified by an Anthem claim.	Up to $200 per member per year

Notes:

- For additional information on this plan, please visit www.sbc.anthem.com to obtain a "Summary of Benefits and Coverage".
- Preferred PCP refers to primary care providers that participate in our EPHC (Enhanced Personal Health Care) program.

Language Access Services:

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) 330-1214

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 1214-330 (855) .

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) 330-1214:

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) 330-1214。

Farsi (فارسي) : 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 1214-330 (855) تماس بگیرید.

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (855) 330-1214.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (855) 330-1214.

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) 330-1214.

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) 330-1214 にお電話ください。

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(855) 330-1214로 문의하십시오.

Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'idiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí łą' bich'į' hadeesdzih ninízingo kojį' hodíilnih (855) 330-1214.

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) 330-1214.

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) 330-1214 ਤੇ ਕਾਲ ਕਰੋ।

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (855) 330-1214.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (855) 330-1214.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (855) 330-1214.

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) 330-1214.

It's important we treat you fairly
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. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.