

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your 2023 Contract Code: 7343

Your Plan: Anthem Gold PPO 500/25%/7000

Your Network: 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.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$500 person / \$1,500 family	\$2,000 person / \$4,000 family
Overall 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.</i>	\$7,000 person / \$14,000 family	\$17,500 person / \$35,000 family
<p><i>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.</i></p> <p><i>In-Network and Non-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.</i></p> <p><i>All medical services subject to a coinsurance are also subject to the annual medical deductible with the exception of facility emergency room charge.</i></p> <p><i>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.</i></p>		
Doctor Visits (virtual and office) <i>You are encouraged to select a Primary Care Physician (PCP).</i>		
Medical Chats and Virtual Visits for Primary Care <i>from our Online Provider K Health, through its affiliated Provider groups are covered at No charge.</i>		
Virtual Visits from online provider LiveHealth Online <i>for urgent/acute medical and mental health and substance abuse care via www.livehealthonline.com are covered at No charge for the first 12 visits and then \$10 copay per visit deductible does not apply.</i>		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Primary Care (PCP) and Mental Health and Substance Abuse Care <i>virtual and office</i> Specialist Care <i>virtual and office</i>	\$25 copay per visit deductible does not apply \$50 copay per visit deductible does not apply	50% coinsurance after deductible is met 50% coinsurance after deductible is met
Other Practitioner Visits Routine Maternity Care (Prenatal and Postnatal) <i>In-Network preventive prenatal services are covered at 100%.</i> Retail Health Clinic Spinal Manipulation <i>Coverage is limited to 50 visits per benefit period.</i> Acupuncture	25% coinsurance after deductible is met \$25 copay per visit deductible does not apply \$25 copay per visit deductible does not apply Not covered	50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met Not covered
Other Services in an Office Allergy Testing Prescription Drugs - Dispensed in the office <i>For the drugs itself dispensed in the office through infusion/injection.</i> Surgery	\$25 copay per visit deductible does not apply 25% coinsurance after deductible is met \$50 copay per surgery deductible does not apply	50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met
Preventive care/screenings/immunizations <i>In-network preventive care is not subject to deductible, if your plan has a deductible.</i>	No charge	50% coinsurance after deductible is met
Preventive care for Chronic Conditions <i>per IRS guidelines</i>	No charge	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
<u>Diagnostic Services</u>		
Lab		
Office	25% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge	50% coinsurance after deductible is met
Outpatient Hospital	25% coinsurance after deductible is met	50% coinsurance after deductible is met
X-Ray		
Office	25% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	\$25 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	25% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging - for example: MRI, PET and CAT scans		
Office	25% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	25% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	25% 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
<u>Emergency and Urgent Care</u>		
Urgent Care (Office Setting)	\$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Emergency Room Facility Services <i>Emergency Room copay is waived if directly admitted to the hospital.</i>	\$500 copay per visit and 25% coinsurance deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	25% coinsurance after deductible is met	Covered as In-Network
Emergency Room Mental Health and Substance Abuse Doctor Services	25% coinsurance deductible does not apply	Covered as In-Network
Ambulance (Air and Ground) <i>Non-emergency, Non-Network ambulance services are limited to an Anthem maximum payment of \$50,000 per trip.</i>	25% coinsurance after deductible is met	Covered as In-Network
<u>Outpatient Mental Health and Substance Abuse Care at a Facility</u>		
Facility Fees	0% coinsurance deductible does not apply	50% coinsurance after deductible is met
Doctor Services	0% coinsurance deductible does not apply	50% coinsurance after deductible is met
<u>Outpatient Surgery</u>		
Facility Fees		
Hospital	25% 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		
Hospital	25% 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
Ambulatory Surgical Center	No charge	50% coinsurance after deductible is met
<u>Hospital Stay (all Inpatient stays including Maternity, Mental Health and Substance Abuse)</u> Facility fees (for example, room & board) <i>Coverage for Inpatient Rehabilitation is limited to 60 days per benefit period.</i> Physician and other services including surgeon fees	25% coinsurance after deductible is met 25% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met
Home Health Care	25% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy) <i>Coverage for physical therapy, occupational therapy and speech therapy is limited to 120 visits combined per benefit period.</i> Office Outpatient Hospital	\$25 copay per visit deductible does not apply 25% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met
Habilitation services (for example, physical/speech/occupational therapy) <i>Coverage for physical therapy, occupational therapy and speech therapy is limited to 120 visits combined per benefit period.</i> Office Outpatient Hospital	\$25 copay per visit deductible does not apply 25% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met
Pulmonary rehabilitation		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Office	\$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	25% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation		
Office	\$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	25% coinsurance after deductible is met	50% coinsurance after deductible is met
Dialysis/Hemodialysis office and outpatient hospital	25% coinsurance after deductible is met	50% coinsurance after deductible is met
Chemo/Radiation Therapy office and outpatient hospital	25% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (in a facility) <i>Coverage is limited to 150 days per benefit period. Limit is combined across a skilled nursing facility and an outpatient day rehabilitation program.</i>	25% coinsurance after deductible is met	50% coinsurance after deductible is met
Inpatient Hospice	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
Prosthetic Devices <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period. Coverage for hearing aids services is limited to 1 item per ear every 3 years.</i>	50% 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: <i>Advantage Network</i> Drug List: <i>Select</i> <i>Drugs not included on the Select drug list will not be covered.</i>		
Day Supply Limits: Retail Pharmacy <i>30 day supply (cost shares noted below)</i> Retail 90 Pharmacy <i>90 day supply (cost shares noted below)</i> Home Delivery Pharmacy <i>90 day supply (maximum cost shares noted below)</i> <i>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.</i> Specialty Pharmacy <i>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.</i>		
Tier 1a - Typically Lower Cost Generic <i>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.</i>	\$10 copay per prescription (retail) and \$25 copay per prescription (home delivery)	50% coinsurance (retail) and Not covered (home delivery)
Tier 1b - Typically Generic <i>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.</i>	\$20 copay per prescription (retail) and \$50 copay per prescription (home delivery)	50% coinsurance (retail) and Not covered (home delivery)
Tier 2 - Typically Preferred Brand <i>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.</i>	\$40 copay per prescription (retail) and \$120 copay per prescription (home delivery)	50% coinsurance (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand <i>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.</i>	\$80 copay per prescription (retail) and \$240 copay per prescription (home delivery)	50% coinsurance (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	25% coinsurance up to \$500 per	50% coinsurance (retail) and Not

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
	prescription (retail and home delivery)	covered (home delivery)

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>		
Children's Vision Essential Health Benefits (up to age 19)		
Child Vision Deductible Vision exam <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.</i>	Not Applicable No charge	Not Applicable \$0 copayment up to plan's Maximum Allowed Amount
Frames <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i>	No charge	\$0 copayment up to plan's Maximum Allowed Amount
Single Vision Lenses <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i>	No charge	\$0 copayment up to plan's Maximum Allowed Amount
Bifocal Vision Lenses <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i>	No charge	\$0 copayment up to plan's Maximum Allowed Amount
Trifocal Vision Lenses <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i>	No charge	\$0 copayment up to plan's Maximum Allowed Amount
Elective contact lenses <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i>	No charge	\$0 copayment up to plan's Maximum Allowed Amount
Non-Elective Contact Lenses <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i>	No charge	\$0 copayment up to plan's Maximum Allowed Amount
Adult Vision (age 19 and older)		
Adult Vision Deductible Vision exam <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.</i>	Not Applicable \$20 copay	Not Applicable 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
<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>	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 a Non-Network Provider and your plan includes out-of-network benefits, you may be required to pay (i) the difference between any amount the plan pays 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 a Non-Network Provider you may have to pay the difference between the Non-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.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.

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。

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) 330-1218 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) 330-1218.

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) 330-1218.

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:

Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'ídiikidgo ná bohónéedzǫ́ dóó bee ahóót'i' t'áá ni nizaad k'ehǫ́ bee níl hodoonih t'áadoo bááh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih nínízingo kojí' hodiílnih (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 ਮੁਫਤ 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।

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) 330-1218.

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) 330-1218.

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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>.