

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your 2024 Contract Code: 9KH6

Your Plan: Anthem Silver PPO DED 4000

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.

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	\$70 copay per visit deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible <i>Your plan applies a separate Pharmacy Deductible to prescription drugs obtained at a pharmacy. See the Covered Prescription Drug Benefits section.</i>	\$4,000 person / \$8,000 family	\$10,000 person / \$20,000 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>	\$9,100 person / \$18,200 family	\$22,750 person / \$45,500 family
<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>		
<i>In-Network and Non-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.</i>		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><i>Your copays, coinsurance and deductible count toward your out-of-pocket limit. However, member cost sharing for the following service(s) do not apply toward the out-of-pocket limit: adult vision, Non-Network Human Organ and Tissue Transplant and Cellular and Gene Therapy.</i></p>		
<p>Doctor Visits (virtual and office) <i>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.</i></p>		
<p>Preferred PCP <i>virtual and office</i></p> <p>Primary Care (PCP) <i>virtual and office</i></p> <p>Mental Health and Substance Use Disorder Services <i>virtual and office</i></p> <p>Specialist Care <i>virtual and office</i></p>	<p>\$35 copay per visit deductible does not apply</p> <p>\$45 copay per visit deductible does not apply</p> <p>\$45 copay per visit deductible does not apply</p> <p>\$70 copay per visit deductible does not apply</p>	<p>Not covered</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p>Other Practitioner Visits</p> <p>Routine Maternity Care (Prenatal and Postnatal) <i>In-Network preventive prenatal services are covered at 100%.</i></p> <p>Retail Health Clinic</p> <p>Chiropractic Services <i>Coverage for rehabilitation and habilitation is limited to 30 visits per benefit period.</i></p> <p>Acupuncture</p>	<p>20% coinsurance after deductible is met</p> <p>\$45 copay per visit deductible does not apply</p> <p>\$45 copay per visit deductible does not apply</p> <p>Not covered</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>Not covered</p>
<p>Other Services in an Office</p> <p>Allergy Testing</p> <p>Prescription Drugs - Dispensed in the office <i>For the drugs itself dispensed in the office through infusion/injection.</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Surgery	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Preventive care/screenings/immunizations	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
<u>Diagnostic Services</u> Lab Office Preferred Reference Lab Outpatient Hospital	20% coinsurance after deductible is met No charge 20% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met
X-Ray Office Freestanding Radiology Center Outpatient Hospital	20% coinsurance after deductible is met \$45 copay per visit deductible does not apply 20% coinsurance after deductible is met	50% coinsurance after deductible is met 50% 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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>\$200 copay per visit deductible does not apply</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><u>Emergency and Urgent Care</u></p> <p>Urgent Care Center Office Visit</p> <p>Emergency Room Facility Services <i>Your copay will be waived if admitted.</i></p> <p>Emergency Room Doctor and Other Services</p> <p>Emergency Room Doctor Services for Mental Health and Substance Use Disorders</p> <p>Ambulance Transportation <i>Authorized Non-Network non-emergency ambulance services are limited to an Anthem maximum payment of \$50,000 per trip.</i></p>	<p>\$70 copay per visit deductible does not apply</p> <p>\$750 copay per visit after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>\$45 copay per visit after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p><u>Outpatient Mental Health and Substance Use Disorder Services at a Facility</u></p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><u>Outpatient Surgery</u></p> <p>Facility Fees</p> <p>Hospital</p> <p>Ambulatory Surgical Center</p>	<p>20% coinsurance after deductible is met</p> <p>\$500 copay per visit deductible does not apply</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Physician and other services including surgeon fees</p> <p>Hospital</p> <p>Ambulatory Surgical Center</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><u>Hospital Stay (all Inpatient stays including Maternity, Mental Health and Substance Use Disorder Services)</u></p> <p>Facility fees (for example, room & board) <i>Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 100 days combined per admission.</i></p> <p>Physician and other services including surgeon fees</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p>Home Health Care <i>Home health visits are 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.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p>
<p>Rehabilitation services (for example, physical/speech/occupational therapy) <i>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.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$45 copay per visit deductible does not apply</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p>Habilitation services (for example, physical/speech/occupational therapy) <i>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.</i></p> <p>Office</p>	<p>\$45 copay per visit deductible does not apply</p>	<p>50% coinsurance after deductible is met</p>

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	\$70 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	\$70 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) <i>Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 100 days combined per admission.</i>	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
<p>Prosthetic Devices <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p>

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible <i>combined for In-Network and Non-Network Pharmacies</i>	\$250 person / \$500 family (does not apply to Tier 1 drugs)	\$250 person / \$500 family (does not apply to Tier 1 drugs)
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: <i>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.</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). Maintenance medications are available through CarelonRx Pharmacy. 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>		
Preventive Drugs <i>See cost shares below for Prescription Drugs on the PreventiveRx Plus list.</i>		
Tier 1 Preventive - 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> Tier 2 Preventive - 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>	\$10 copay per prescription, Pharmacy deductible does not apply (retail) \$45 copay per prescription, Pharmacy deductible does not apply (retail)	50% coinsurance, Pharmacy deductible does not apply (retail) and Not covered (home delivery) 50% coinsurance after Pharmacy deductible is met (retail) and Not covered (home delivery)
Tier 1 - 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. 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.</i>	\$15 copay per prescription, Pharmacy deductible does not apply (retail) and \$30 copay per	50% coinsurance, Pharmacy deductible does not apply (retail) and Not covered (home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
	prescription, Pharmacy deductible does not apply (home delivery)	
<p>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. 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.</i></p>	\$45 copay per prescription after Pharmacy deductible is met (retail) and \$113 copay per prescription after Pharmacy deductible is met (home delivery)	50% coinsurance after Pharmacy deductible is met (retail) and Not covered (home delivery)
<p>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. 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.</i></p>	25% coinsurance up to \$200 per prescription after Pharmacy deductible is met (retail) and 25% coinsurance up to \$500 per prescription after Pharmacy deductible is met (home delivery)	50% coinsurance after Pharmacy deductible is met (retail) and Not covered (home delivery)
<p>Tier 4 - Typically Specialty (brand and generic) <i>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.</i></p>	25% coinsurance up to \$400 per prescription after Pharmacy deductible is met (retail and home delivery)	50% coinsurance after Pharmacy deductible is met (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
<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. 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 No charge</p>	<p>Not Applicable Not covered</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>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 \$20 copay</p>	<p>Not Applicable Reimbursed Up to \$30</p>
<p>Frames</p>	<p>Not covered</p>	<p>Not covered</p>
<p>Single Vision Lenses</p>	<p>Not covered</p>	<p>Not covered</p>

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>		
<p>Children's Dental Essential Health Benefits Diagnostic and preventive <i>Coverage for In-Network Providers and Non-Network Providers combined is limited to 2 visits per 12 months.</i></p>	<p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p>Basic services</p>	<p>40% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p>
<p>Major services</p>	<p>50% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p>
<p>Medically Necessary Orthodontia services</p>	<p>50% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p>
<p>Cosmetic Orthodontia services</p>	<p>Not covered</p>	<p>Not covered</p>
<p>Deductible</p>	<p>Combined with medical deductible</p>	<p>Combined with medical deductible</p>
<p>Adult Dental</p>		
<p>Diagnostic and preventive</p>	<p>Not covered</p>	<p>Not covered</p>
<p>Basic services</p>	<p>Not covered</p>	<p>Not covered</p>
<p>Major services</p>	<p>Not covered</p>	<p>Not covered</p>
<p>Deductible</p>	<p>Not covered</p>	<p>Not covered</p>
<p>Annual maximum</p>	<p>Not covered</p>	<p>Not covered</p>

Healthy Support & Rewards

To see your rewards and additional information log into the Anthem website at [anthem.com](https://www.anthem.com) or call the customer service number on your member ID card.

Program Name	Program Description	Program Incentive
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”.
- 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.

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Questions: (855) 330-1214 or visit us at www.anthem.com

VA/SG/Anthem Silver PPO DED 4000/9KH6/01-01-2024

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 (855) 330-1214.

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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.

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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) 330-1214 にお電話ください。

Language Access Services:

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.

Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'idiikidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehj̄ bee nił hodoonih t'áadoo bááh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih ninízingo koj̄' hodiłnił (855) 330-1214.

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