



The Summary of Benefits and Coverage (SBC) document will help you choose a health **plan**. The SBC shows you how you and the **plan** would share the cost for covered health care services. **NOTE:** Information about the cost of this **plan** (called the **premium**) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, <https://eoc.anthem.com/eocdps/75X5SH07012023L05761MD11>. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call (844) 412-0752 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	\$7,000/person.	Generally, you must pay all of the costs from <b>providers</b> up to the <b>deductible</b> amount before this <b>plan</b> begins to pay. If you have other family members on the <b>plan</b> , each family member must meet their own individual <b>deductible</b> until the total amount of <b>deductible</b> expenses paid by all family members meets the overall family <b>deductible</b> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. <b>Preventive Care</b> . Vision. For more information see below.	This <b>plan</b> covers some items and services even if you haven't yet met the <b>deductible</b> amount. But a <b>copayment</b> or <b>coinsurance</b> may apply. For example, this <b>plan</b> covers certain <b>preventive services</b> without <b>cost-sharing</b> and before you meet your <b>deductible</b> . See a list of covered <b>preventive services</b> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	Yes. There are no other specific <b>deductibles</b> .	You must pay all of the costs for these services up to the specific <b>deductible</b> amount before this <b>plan</b> begins to pay for these services.
<b>What is the <u>out-of-pocket limit</u> for this <b>plan</b>?</b>	\$8,700/person or \$17,400/family.	The <b>out-of-pocket limit</b> is the most you could pay in a year for covered services. If you have other family members in this <b>plan</b> , they have to meet their own <b>out-of-pocket limits</b> until the overall family <b>out-of-pocket limit</b> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<b>Premiums</b> , <b>balance-billing</b> charges, health care this <b>plan</b> doesn't cover, and Non- <b>Network</b> Transplants.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes, KeyCare. See <a href="https://www.anthem.com/health-insurance/provider-directory/searchcriteria?planstate=VA&amp;plantype=PPOGRP&amp;planname=Anthem+KeyCare+P">https://www.anthem.com/health-insurance/provider-directory/searchcriteria?planstate=VA&amp;plantype=PPOGRP&amp;planname=Anthem+KeyCare+P</a>	This <b>plan</b> uses a <b>provider network</b> . You will pay less if you use a <b>provider</b> in the <b>plan's network</b> . You will pay the most if you use an <b>Out-of-Network Provider</b> , and you might receive a bill from a <b>provider</b> for the difference between the <b>provider's</b> charge and what your <b>plan</b> pays ( <b>balance billing</b> ). Be aware your <b>network provider</b> might use an <b>Out-of-Network Provider</b> for some services (such as lab work). Check with your <b>provider</b> before you get

	<a href="#">PO</a> or call (844) 412-0752 for a list of <a href="#">network providers</a> . Costs may vary by site of service and how the provider bills.	services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Virtual visits (Telehealth) benefits available.
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Virtual visits (Telehealth) benefits available.
	<a href="#">Preventive care</a> / <a href="#">screening</a> /immunization	No charge	40% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need drugs to treat your illness or condition  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a>	Tier 1 - Typically Generic	50% <a href="#">coinsurance</a> , Prescription Drug <a href="#">deductible</a> applies (retail and home delivery)	50% <a href="#">coinsurance</a> , Prescription Drug <a href="#">deductible</a> applies (retail) and Not covered (home delivery)	*See Prescription Drug section
	Tier 2 - Typically Preferred Brand & Non-Preferred Generic Drugs	50% <a href="#">coinsurance</a> , Prescription Drug <a href="#">deductible</a> applies (retail and home delivery)	50% <a href="#">coinsurance</a> , Prescription Drug <a href="#">deductible</a> applies (retail) and Not covered (home delivery)	
	Tier 3 - Typically Non-Preferred Brand and Generic drugs	50% <a href="#">coinsurance</a> , Prescription Drug <a href="#">deductible</a> applies (retail and home delivery)	50% <a href="#">coinsurance</a> , Prescription Drug <a href="#">deductible</a> applies (retail) and Not covered (home delivery)	
Traditional Open Drug List				

\* For more information about limitations and exceptions, see the [plan](#) or policy document at  
<https://eoc.anthem.com/eocdps/75X5SH07012023L05761MD11>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	Covered as In- <a href="#">Network</a>	-----none-----
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	Covered as In- <a href="#">Network</a>	-----none-----
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit 20% <a href="#">coinsurance</a>	Office Visit 40% <a href="#">coinsurance</a>	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient -----none-----
		Other Outpatient 20% <a href="#">coinsurance</a>	Other Outpatient 40% <a href="#">coinsurance</a>	
	Inpatient services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
	Office visits	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
If you are pregnant	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	*See Therapy Services section.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	*See <a href="#">Durable Medical Equipment</a> Section
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Children's eye exam	No charge	Reimbursed Up to \$30	*See Vision Services section
If your child needs dental or eye care	Children's glasses	No charge	Reimbursed Up to \$55	
	Children's dental check-up	No charge	No charge	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://eoc.anthem.com/eocdps/75X5SH07012023L05761MD11>.

## Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Routine eye care (Adult)
- Dental care (Adult)
- Routine foot care unless [medically necessary](#)
- Long-term care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Acupuncture
- Hearing aids
- Private-duty nursing 16 hours/benefit period in a Home Setting only
- Bariatric surgery
- Infertility treatment
- Chiropractic care
- Most coverage provided outside the United States. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Virginia Bureau of Insurance, 1300 East Main Street, P. O. Box 1157, Richmond, VA 23218, (800) 552-7945, or contact Anthem at the number on the back of your ID card. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact:

ATTN: Grievances and Appeals, P.O. Box 27401, Richmond, VA 23279

Virginia Bureau of Insurance, 1300 East Main Street, P. O. Box 1157, Richmond, VA 23218, (800) 552-7945

**Does this plan provide Minimum Essential Coverage? Yes/No**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet the Minimum Value Standards? Yes/No**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://eoc.anthem.com/eocdps/75X5SH07012023L05761MD11>.

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#)
- [Specialist coinsurance](#)
- Hospital (facility) [coinsurance](#)
- Other [coinsurance](#)

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#)
- [Specialist coinsurance](#)
- Hospital (facility) [coinsurance](#)
- Other [coinsurance](#)

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#)
- [Specialist coinsurance](#)
- Hospital (facility) [coinsurance](#)
- Other [coinsurance](#)

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
Childbirth/Delivery Professional Services  
Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

Total Example Cost

\$12,700

In this example, Peg would pay:

#### *Cost Sharing*

<a href="#">Deductibles</a>	\$7,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,100

#### *What isn't covered*

Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$8,160</b>

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost

\$5,600

In this example, Joe would pay:

#### *Cost Sharing*

<a href="#">Deductibles</a>	\$1,600
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,900

#### *What isn't covered*

Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$3,520</b>

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost

\$2,800

In this example, Mia would pay:

#### *Cost Sharing*

<a href="#">Deductibles</a>	\$2,800
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0

#### *What isn't covered*

Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

## Language Access Services:

(TTY/TDD: 711)

**Albanian (Shqip):** Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (844) 412-0752

**Amharic (አማርኛ):** ከለሃሱ ሌሎች ማንኛውም ቅጽች ከለዋኑ በረከም ቅጽች እና ይህን መረጃ በንግድ የሚገኘት መብት አለዋኑ:: አስተዳደጋለሁ (844) 412-0752 የፈጻሚ::

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (844) 412-0752.

**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՝ (844) 412-0752:

**Bassa (Bāsawò Wùqdù):** M dyi dyi-diè-dè bá cèè-dè nià kë dyí ní, o mò nì dyí-bèdèèn-dè bá m kë gbo-kpá-kpá kë bá kpá dë m bídí-wùqdùún bó pídyi. Bé m kë wuqu-zììn-nyò dò gbo wùqdù kë, dá (844) 412-0752.

**Bengali (বাংলা):** যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় **বিলামূল্য** সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাসীর সাথে কথা স্লার জন্য (844) 412-0752 -তে কল করুন।

**Burmese (မြန်မာ):** ဤတရုပ်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် ဖော်မြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကျအညီကို အခြောက်းငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ ဝကားပြန် တစ်ဦးနှင့် ဝကားပြောနိုင်ရန် ဒါ (844) 412-0752 သို့ ခေါ်ဆိုပါ။

**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(844) 412-0752。

**Dinka (Dinka):** Na noj thiëec në ke de yä thorë, ke yin noj loj bë yi kuony ku wer alëu bë geer yic yin ne thoj du ke cin wëu tääüë ke piny. Te kör yin ba jam wënë ran ye thok geryic, ke yin cö (844) 412-0752.

**Dutch (Nederlands):** Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (844) 412-0752.

**Farsi (فارسی):** در صورتی که سوالی 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 (844) 412-0752 تماس بگیرید.

## Language Access Services:

**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 (844) 412-0752.

**German (Deutsch)**: Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (844) 412-0752.

**Greek (Ελληνικά)** Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (844) 412-0752.

**Gujarati (ગુજરાતી)**: જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (844) 412-0752.

**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 entèpèt, rele (844) 412-0752.

**Hindi (हिंदी)**: अगर आपके पास इस दस्तावेज के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है।  
दुभाषिये से बात करने के लिए, कॉल करें (844) 412-0752 |

**Hmong (White Hmong)**: Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (844) 412-0752.

**Igbo (Igbo)**: O bùr ụ na i nwere ajụụ ọ bụla gbasara akwụkwọ a, i nwere ikike ịnweta enyemaka na ozi n'asụṣụ gi na akwụghị ugwo ọ bụla. Ka gi na ọkowa okwu kwuo okwu, kpọọ (844) 412-0752.

**Ilokano (Ilokano)**: Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (844) 412-0752.

**Indonesian (Bahasa Indonesia)**: Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (844) 412-0752.

**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 (844) 412-0752

**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 (844) 412-0752 にお電話ください。

## Language Access Services:

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