

Your summary of benefits



Anthem® Blue Cross and Blue Shield

SIP Vegetation - Plan Year 01/01/2025 – 12/31/2025

Your Plan: Anthem HSA 6500/0%/6525 Rx \$15/\$50/\$85/20% PreventiveRx Plus

Your Network: KeyCare

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge after deductible is met
Mental Health & Substance Use Disorder Services	No charge after deductible is met
Specialist care	No charge after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	\$6,500 person / \$13,000 family	\$13,000 person / \$26,000 family
Overall Out-of-Pocket Limit	\$6,525 person / \$13,050 family	\$13,050 person / \$26,100 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 person deductible and per person 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 person deductible or per person out-of-pocket limit. All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit (excluding Out-of-Network Human Organ and Tissue Transplant (HOTT), Cellular and Gene Therapy services). In-Network and Out-of-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.		
Doctor Visits (virtual and office) <i>You are encouraged to select a Primary Care Physician (PCP).</i>		
Primary Care (PCP) and Mental Health and Substance Use Disorder Services <i>virtual and office</i>	No charge after deductible is met	40% coinsurance after deductible is met
Specialist Care <i>virtual and office</i>	No charge after deductible is met	40% coinsurance after deductible is met
<u>Other Practitioner Visits</u>		
Maternity Doctor services (prenatal/postnatal care and delivery)	No charge after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i>	No charge after deductible is met	40% coinsurance after deductible is met
Manipulation Therapy <i>Coverage is limited to 30 visits per benefit period.</i>	No charge after deductible is met	40% coinsurance after deductible is met
<u>Other Services in an Office</u>		
Allergy Testing	No charge after deductible is met	40% coinsurance after deductible is met
Prescription Drugs <i>Dispensed in the office</i>	No charge after deductible is met	40% coinsurance after deductible is met
Surgery	No charge after deductible is met	40% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	40% coinsurance after deductible is met
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	40% coinsurance after deductible is met
<u>Diagnostic Services</u>		
Lab		
Office	No charge after deductible is met	40% coinsurance after deductible is met
Reference Lab	No charge after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	No charge after deductible is met	40% coinsurance after deductible is met
X-Ray		
Office	No charge after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	No charge after deductible is met	40% coinsurance after deductible is met
Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i>		
Office	No charge after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	No charge after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<u>Emergency and Urgent Care</u> Urgent Care Emergency Room Facility Services Emergency Room Doctor and Other Services Ambulance <i>Non-emergency Out-of-Network ambulance services are limited to an Anthem maximum payment of \$50,000 per trip. The \$50,000 limit does not apply to air ambulance services.</i>	No charge after deductible is met No charge after deductible is met No charge after deductible is met No charge after deductible is met No charge after deductible is met	40% coinsurance after deductible is met Covered as In-Network Covered as In-Network Covered as In-Network
<u>Outpatient Mental Health and Substance Use Disorder Services at a Facility</u> Facility Fees Doctor Services	No charge after deductible is met No charge after deductible is met	40% coinsurance after deductible is met 30% coinsurance after deductible is met
<u>Outpatient Surgery</u> Facility Fees Hospital Ambulatory Surgical Center Physician and other services including surgeon fees Hospital	No charge after deductible is met No charge after deductible is met No charge after deductible is met No charge after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met
<u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u> Facility Fees Physician and other services including surgeon fees	No charge after deductible is met No charge after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met
Home Health Care <i>Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.</i>	No charge after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies.</i> <i>Coverage for physical and occupational therapies is limited to 30 visits combined per benefit period. Coverage for speech therapy is limited to 30 visits per benefit period.</i>		
Office	No charge after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	No charge after deductible is met	40% coinsurance after deductible is met
Pulmonary rehabilitation <i>office and outpatient hospital</i>	No charge after deductible is met	40% coinsurance after deductible is met
Cardiac rehabilitation <i>office and outpatient hospital</i> <i>Coverage is limited to 36 visits per benefit period.</i>	No charge after deductible is met	40% coinsurance after deductible is met
Dialysis/Hemodialysis <i>office and outpatient hospital</i>	No charge after deductible is met	40% coinsurance after deductible is met
Chemo/Radiation Therapy <i>office and outpatient hospital</i>	No charge after deductible is met	40% coinsurance after deductible is met
Skilled Nursing Care (facility) <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.</i>	No charge after deductible is met	40% coinsurance after deductible is met
Inpatient Hospice	No charge after deductible is met	40% coinsurance after deductible is met
Durable Medical Equipment	No charge after deductible is met	40% coinsurance after deductible is met
Prosthetic Devices <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	No charge after deductible is met	40% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with Out-of-Network medical deductible
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Out-of-Network medical out-of-pocket limit
Prescription Drug Coverage: PreventiveRx Plus 100% before deductible Network: <i>Base Network</i> Drug List: <i>National</i> <i>Drugs not included on the National 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 (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).</i> Home Delivery Pharmacy <i>90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery 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>The deductible does not apply to prescription drugs on the PreventiveRX Plus drug list when you use an In-Network Pharmacy.</i>		
Tier 1 - Typically Generic	\$15 copay per prescription after deductible is met (retail) and \$38 copay per prescription after deductible is met (home delivery)	40% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 - Typically Preferred Brand	\$50 copay per prescription after deductible is met (retail) and \$125 copay per prescription after deductible is met (home delivery)	40% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	\$85 copay per prescription after deductible is met (retail) and \$213 copay per prescription after deductible is met (home delivery)	40% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	20% coinsurance up to \$300 per prescription after deductible is met (retail and home delivery)	40% coinsurance after deductible is met (retail) and Not covered (home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<i>This is a brief outline of your vision coverage. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out-of-pocket limit.</i>		
Children's Vision exam (up to age 19) <i>Limited to 1 exam per benefit period.</i>	No charge	\$0 copayment up to plan's Maximum Allowed Amount
Adult Vision exam (age 19 and older) <i>Limited to 1 exam per benefit period.</i>	\$15 copay	Reimbursed Up to \$30

Notes:

- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- 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.
- The representations of benefits in this document are subject to Virginia Bureau of Insurance (BOI) approval and are subject to change.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. 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 contact us. If there is a difference between this summary and the contract of coverage, the contract of coverage 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.

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Questions: (833) 592-9956 or visit us at www.anthem.com

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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 (833) 592-9956

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 (833) 592-9956.

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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 (833) 592-9956.

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Navajo (Diné): Díí naaltsoos biká'ígíí lahgo bina'ídiłkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj bee níl hodoonih t'áadoo báąh ilínígóó. Ata' halne'ígíí ła' bich'í' hadeesdzih nínízingo koj' hodiłnih (833) 592-9956.

Language Access Services:

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: (833) 592-9956.

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