Your summary of benefits

Anthem

Anthem® Blue Cross and Blue Shield

Your 2024 Contract Code: 9Y7F

Your Plan: Anthem Platinum EPO 20/40 0% WH

Your Network: PPO/EPO

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. Unless stated otherwise, 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 Certificate of Insurance or Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

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	$40 copay per visit

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *Your plan applies a separate Pharmacy Deductible to prescription drugs obtained at a pharmacy. See the Covered Prescription Drug Benefits section.*	$0 person / $0 family	Not covered
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.*	$3,000 person / $6,000 family	Not covered
The family out-of-pocket limit is embedded, meaning each covered person is capped at his or her per member out-of-pocket limit; in addition, cost shares for all covered family members apply to the family out-of-pocket limit, yet no one member will pay more than the per member out-of-pocket limit.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Primary Care (PCP) and Mental Health and Substance Use Disorder Services *virtual and office*	$20 copay per visit	Not covered
Specialist Care *virtual and office*	$40 copay per visit	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Other Practitioner Visits		
Routine Maternity Care		
Prenatal *In-Network preventive prenatal services are covered at 100%.*	No charge	Not covered
Postnatal	$40 copay per visit	Not covered
Retail Health Clinic	$20 copay per visit	Not covered
Chiropractic Services	$40 copay per visit	Not covered
Acupuncture	$40 copay per visit	Not covered
Other Services in an Office		
Allergy Testing	No charge	Not covered
Prescription Drugs - Dispensed in the office *For the drugs itself dispensed in the office through infusion/injection.*	$500 copay per visit	Not covered
Surgery	$40 copay per surgery	Not covered
Preventive care/screenings/immunizations	No charge	Not covered
Diagnostic Services		
Lab		
Office	No charge	Not covered
Freestanding Laboratory Facility *Anthem's participating Freestanding Labs are Laboratory Corporation of America or Quest Diagnostics. Please check Provider Finder for additional participating Freestanding Labs in your area.*	No charge	Not covered
Outpatient Hospital	No charge	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
X-Ray		
Office	$50 copay per visit	Not covered
Outpatient Hospital	$150 copay per visit	Not covered
Advanced Diagnostic Imaging - for example: MRI, PET and CAT scans		
Office	$150 copay per visit	Not covered
Outpatient Hospital	$250 copay per visit	Not covered
Emergency and Urgent Care		
Urgent Care Center Office Visit	$50 copay per visit	Covered as In-Network
Emergency Room Facility Services *Your copay will be waived if admitted.*	$300 copay per visit	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	Covered as In-Network
Ambulance Transportation	$300 copay per trip	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees *Family counseling related to Substance Use Disorders is limited to 20 visits per year. Coinsurance limited to the copay amount reflected for Primary Care Office visit.*	$20 copay per visit	Not covered
Doctor Services *Family counseling related to Substance Use Disorders is limited to 20 visits per year.*	No charge	Not covered
Outpatient Surgery		
Facility Fees		
Hospital	$500 copay per visit	Not covered
Ambulatory Surgical Center	$50 copay per visit	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Physician and other services		
Hospital	No charge	Not covered
Ambulatory Surgical Center	No charge	Not covered
Surgeon Fees		
Hospital	$20 copay per visit	Not covered
Ambulatory Surgical Center	No charge	Not covered
Hospital Stay (all Inpatient stays including Maternity, Mental Health and Substance Use Disorder Services) *If readmitted within 90 days for the same or related condition, no additional facility copay is required. If transferred between facilities, only one copay will apply.*		
Facility fees (for example, room & board) *Coverage for Inpatient Rehabilitation is limited to 60 days per benefit period.*	$500 copay per admission	Not covered
Physician and other services including surgeon fees	No charge	Not covered
Home Health Care *Coverage is limited to 40 visits per benefit period. Benefit limit and cost share applies to physical, occupational, speech, respiratory, cardiac and pulmonary therapy when performed as part of Home Health.*	$40 copay per visit	Not covered
Rehabilitation services (for example, physical/speech/occupational therapy) *Coverage for physical therapy, occupational therapy and speech therapy is limited to 60 visits combined per benefit period.*		
Office	$20 copay per visit	Not covered
Outpatient Hospital	$40 copay per visit	Not covered
Habilitation services (for example, physical/speech/occupational therapy) *Coverage for physical therapy, occupational therapy and speech therapy is limited to 60 visits combined per benefit period.*		
Office	$20 copay per visit	Not covered
Outpatient Hospital	$40 copay per visit	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pulmonary rehabilitation office and outpatient hospital	$40 copay per visit	Not covered
Cardiac rehabilitation office and outpatient hospital	$40 copay per visit	Not covered
Dialysis/Hemodialysis office and outpatient hospital *Coverage is limited to 10 visits per benefit period with Non-Network provider.*	No charge	Covered as In-Network
Radiation/Chemotherapy/Non Preventive Infusion & Injection		
Office	No charge	Not covered
Outpatient Hospital	$40 copay per visit	Not covered
Skilled Nursing Care (in a facility)	$500 copay per admission	Not covered
Inpatient Hospice	No charge	Not covered
Durable Medical Equipment	50% coinsurance	Not covered
Prosthetic Devices	50% coinsurance	Not covered

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	$100 person / $200 family (does not apply to Tier 1 drugs)	Not covered
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Not covered
Prescription Drug Coverage **Network:** ***Base Network*** **Drug List:** ***Traditional Open*** *If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply. 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.*		
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 Pharmacy. 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.*	$10 copay per prescription, Pharmacy deductible does not apply (retail) and $25 copay per prescription, Pharmacy deductible does not apply (home delivery)	Not covered (retail and 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.*	$35 copay per prescription after Pharmacy deductible is met (retail) and $88 copay per prescription after Pharmacy deductible is met (home delivery)	Not covered (retail and home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Tier 3 - Typically Non-Preferred Brand/Specialty Drugs *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.*	$70 copay per prescription after Pharmacy deductible is met (retail) and $175 copay per prescription after Pharmacy deductible is met (home delivery)	Not covered (retail and 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 *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	$100 Allowance	Reimbursed Up to $45

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Single Vision Lenses *Coverage for Eye Glass Lenses or Contact Lens In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	$20 copay	Reimbursed Up to $25
Bifocal Vision Lenses *Coverage for Eye Glass Lenses or Contact Lens In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	$20 copay	Reimbursed Up to $40
Trifocal Vision Lenses *Coverage for Eye Glass Lenses or Contact Lens In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	$20 copay	Reimbursed Up to $55
Elective contact lenses *Coverage for Eye Glass Lenses or Contact Lens In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	$80 Allowance	Reimbursed Up to $60
Non-Elective Contact Lenses *Coverage for Eye Glass Lenses or Contact Lens In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $210

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 is limited to 2 visits per Benefit Period.*	No charge	No charge
Basic services	No charge	No charge
Major services	50% coinsurance	50% coinsurance
Medically Necessary Orthodontia services	50% coinsurance	50% coinsurance
Cosmetic Orthodontia services	Not covered	Not covered
Deductible	$50	$50
Adult Dental		
Diagnostic and preventive *Coverage for In-Network Providers and Non-Network Providers is limited to 2 visits per Benefit Period.*	No charge	No charge
Basic services	20% coinsurance	20% coinsurance
Major services	50% coinsurance	50% coinsurance
Deductible	$50	$50
Annual maximum	$1,000	$1,000

Healthy Support & Rewards

To see your rewards and additional information log into the Anthem website at anthembluecross.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
Gym Reimbursement	Subscriber, spouse, and dependents age 18 and over can get money back for using a gym. Fitness membership dues, up to $400, are covered if you're a member of this plan. Work out 50 times at a qualifying fitness center for each six-month period within your benefit plan year. Benefit plan year is the yearly period of coverage that starts at the effective date of coverage.	

Notes:

- Benefit period refers to both calendar year and plan year.
- For additional information on this plan, please visit www.sbc.anthem.com to obtain a "Summary of Benefits and Coverage".
- Anthem's Service Area: Albany, Bronx, Clinton, Columbia, Delaware, Dutchess, Essex, Fulton, Green, Kings, Montgomery, Nassau, New York, Orange, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington and Westchester.
- The prescription drug plan listed on this Summary meets the Centers for Medicare and Medicaid Services (CMS) standard for Creditable Coverage under the Medicare Modernization Act of 2003.
- 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.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.
- Covered Infertility services: lab and radiology tests, cryopreservation, fertility drugs, surgical treatments such as: Artificial Insemination. Benefit also includes coverage of sperm and oocyte (egg) collection related to medical treatment that may cause iatrogenic infertility. Cost share will be applied based on service and setting.
- Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, 3D mammography, breast ultrasounds and MRIs are covered in full as required by state mandate.

Questions: (855) 330-1105 or visit us at www.anthem.com

NY/SG/Anthem Platinum EPO 20/40 0% WH/9Y7F/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) 330-1105

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) 330-1105 .

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) 330-1105:

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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 (855) 330-1105 تماس بگیرید.

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Language Access Services:

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Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'ídiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ąh ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínízingo kojį' hodíílnih (855) 330-1105.

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) 330-1105.

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) 330-1105 ਤੇ ਕਾਲ ਕਰੋ।

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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.