

# Your summary of benefits



Anthem® Blue Cross

Your 2025 Contract Code: 8AF8

Your Plan: Anthem Gold EPO 25/50 0%

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
<b>Primary Care, and medical services for urgent/acute care</b>	No charge
<b>Mental Health &amp; Substance Use Disorder Services</b>	No charge
<b>Specialist care</b>	\$50 copay per visit

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<b>Overall Deductible</b> <i>Your plan applies a separate Pharmacy Deductible to prescription drugs obtained at a pharmacy. See the Covered Prescription Drug Benefits section.</i>	\$0 person / \$0 family	Not covered
<b>Overall Out-of-Pocket Limit</b> <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>	\$8,700 person / \$17,400 family	Not covered
<i>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.</i>		
<b>Doctor Visits (virtual and office)</b> <i>You are encouraged to select a Primary Care Physician (PCP).</i>		
<b>Primary Care (PCP)</b> <i>virtual and office</i>	\$25 copay per visit	Not covered
<b>Mental Health and Substance Use Disorder Services</b> <i>virtual and office</i>	No charge	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<b>Specialist Care</b> <i>virtual and office</i>	\$50 copay per visit	Not covered
<b>Other Practitioner Visits</b>		
Maternity Doctor services		
Prenatal care <i>In-Network preventive prenatal services are covered at 100%.</i>	No charge	Not covered
Delivery	\$50 copay per pregnancy	Not covered
Postnatal care	\$50 copay per visit	Not covered
Retail Health Clinic	\$25 copay per visit	Not covered
Chiropractic Services	\$50 copay per visit	Not covered
Acupuncture	\$50 copay per visit	Not covered
<b>Other Services in an Office</b>		
Allergy Testing	No charge	Not covered
Prescription Drugs - Dispensed in the office <i>For the drugs itself dispensed in the office through infusion/injection.</i>	\$500 copay per visit	Not covered
Surgery	\$50 copay per surgery	Not covered
<b>Preventive care/screenings/immunizations</b>	No charge	Not covered
<b>Preventive care for Chronic Conditions</b> <i>per IRS guidelines</i>	No charge	Not covered
<b><u>Diagnostic Services</u></b>		
<b>Lab</b>		
Office	No charge	Not covered
Freestanding Laboratory Facility <i>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.</i>	No charge	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Hospital	No charge	Not covered
<b>X-Ray</b>		
Office	\$50 copay per visit	Not covered
Outpatient Hospital	\$150 copay per visit	Not covered
<b>Advanced Diagnostic Imaging</b> - for example: MRI, PET and CAT scans		
Office	\$150 copay per visit	Not covered
Outpatient Hospital	\$250 copay per visit	Not covered
<b><u>Emergency and Urgent Care</u></b>		
<b>Urgent Care Center Office Visit</b>	\$75 copay per visit	Covered as In-Network
<b>Emergency Room Facility Services</b> <i>Your copay will be waived if admitted.</i>	\$850 copay per visit	Covered as In-Network
<b>Emergency Room Doctor and Other Services</b>	No charge	Covered as In-Network
<b>Ambulance Transportation</b>	\$850 copay per trip	Covered as In-Network
<b><u>Outpatient Mental Health and Substance Use Disorder Services at a Facility</u></b>		
Facility Fees <i>Family counseling related to Substance Use Disorders is limited to 20 visits per year.</i>	No charge	Not covered
Doctor Services <i>Family counseling related to Substance Use Disorders is limited to 20 visits per year.</i>	No charge	Not covered
<b><u>Outpatient Surgery</u></b>		
<b>Facility Fees</b>		
Hospital	\$500 copay per visit	Not covered
Ambulatory Surgical Center	\$250 copay per visit	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<b>Physician and other services</b> Hospital Ambulatory Surgical Center  <b>Surgeon Fees</b> Hospital Ambulatory Surgical Center	No charge No charge  \$25 copay per visit No charge	Not covered Not covered  Not covered Not covered
<b><u>Hospital Stay (all Inpatient stays including Maternity, Mental Health and Substance Use Disorder Services)</u></b> <i>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.</i>  <b>Facility fees (for example, room &amp; board)</b> <i>Coverage for Inpatient Rehabilitation is limited to 60 days per benefit period.</i>  <b>Physician and other services including surgeon fees</b>	 \$500 copay per admission No charge	 Not covered Not covered
<b>Home Health Care</b> <i>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.</i>	\$50 copay per visit	Not covered
<b>Rehabilitation services (for example, physical/speech/occupational therapy)</b> <i>Coverage for physical therapy, occupational therapy and speech therapy is limited to 60 visits combined per benefit period.</i>  Office Outpatient Hospital	 \$25 copay per visit \$50 copay per visit	 Not covered Not covered
<b>Habilitation services (for example, physical/speech/occupational therapy)</b> <i>Coverage for physical therapy, occupational therapy and speech therapy is limited to 60 visits combined per benefit period.</i>  Office Outpatient Hospital	 \$25 copay per visit \$50 copay per visit	 Not covered Not covered

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

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
<b>Pharmacy Deductible</b>	\$200 person / \$400 family (does not apply to Tier 1 drugs)	Not covered
<b>Pharmacy Out-of-Pocket Limit</b>	Combined with In-Network medical out-of-pocket limit	Not covered
<b>Prescription Drug Coverage</b> <b>Network: <i>Base Network</i></b> <b>Drug List: <i>Traditional Open</i></b> <i>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.</i>		
<b>Day Supply Limits:</b> <b>Retail Pharmacy</b> <i>30 day supply (cost shares noted below)</i> <b>Retail 90 Pharmacy</b> <i>90 day supply (cost shares noted below)</i> <b>Home Delivery Pharmacy</b> <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> <b>Specialty Pharmacy</b> <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>		
<b>Tier 1 - Typically Generic</b> <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) and \$25 copay per prescription, Pharmacy deductible does not apply (home delivery)	Not covered (retail and home delivery)
<b>Tier 2 - Typically Preferred Brand</b> <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>	\$65 copay per prescription after Pharmacy deductible is met (retail) and \$163 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 an Out-of-Network Pharmacy
<b>Tier 3 - Typically Non-Preferred Brand/Specialty Drugs</b> <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>	\$95 copay per prescription after Pharmacy deductible is met (retail) and \$238 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 an Out-of-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>		
<b>Children's Vision Essential Health Benefits (up to age 19)</b>		
<b>Child Vision Deductible</b>	Not applicable	Not applicable
<b>Vision exam</b> <i>Coverage for In-Network Providers is limited to 1 exam per benefit period.</i>	No charge	Not covered
<b>Frames</b> <i>Coverage for In-Network Providers is limited to 1 unit per benefit period.</i>	No charge	Not covered
<b>Single Vision Lenses</b> <i>Coverage for In-Network Providers is limited to 1 unit per benefit period.</i>	No charge	Not covered
<b>Bifocal Vision Lenses</b> <i>Coverage for In-Network Providers is limited to 1 unit per benefit period.</i>	No charge	Not covered
<b>Trifocal Vision Lenses</b> <i>Coverage for In-Network Providers is limited to 1 unit per benefit period.</i>	No charge	Not covered
<b>Elective contact lenses</b> <i>Coverage for In-Network Providers is limited to 1 unit per benefit period.</i>	No charge	Not covered
<b>Non-Elective Contact Lenses</b> <i>Coverage for In-Network Providers is limited to 1 unit per benefit period.</i>	No charge	Not covered
<b>Adult Vision (age 19 and older)</b>		
<b>Adult Vision Deductible</b>	Not applicable	Not applicable
<b>Vision exam</b> <i>Coverage for In-Network Providers is limited to 1 exam per benefit period.</i>	\$20 copay	Not covered
<b>Frames</b>	Not covered	Not covered
<b>Single Vision Lenses</b>	Not covered	Not covered
<b>Bifocal Vision Lenses</b>	Not covered	Not covered
<b>Trifocal Vision Lenses</b>	Not covered	Not covered
<b>Elective contact lenses</b>	Not covered	Not covered
<b>Non-Elective Contact Lenses</b>	Not covered	Not covered



Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-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>		
<b>Children's Dental Essential Health Benefits</b>		
<b>Diagnostic and preventive</b> <i>Coverage for In-Network Providers is limited to 2 visits per Benefit Period.</i>	No charge	Not covered
<b>Basic services</b>	No charge	Not covered
<b>Major services</b>	50% coinsurance	Not covered
<b>Medically Necessary Orthodontia services</b>	50% coinsurance	Not covered
<b>Cosmetic Orthodontia services</b>	Not covered	Not covered
<b>Deductible</b>	Not applicable	Not covered
<b>Adult Dental</b>		
<b>Diagnostic and preventive</b>	Not covered	Not covered
<b>Basic services</b>	Not covered	Not covered
<b>Major services</b>	Not covered	Not covered
<b>Deductible</b>	Not covered	Not covered
<b>Annual maximum</b>	Not covered	Not covered

## Healthy Support & Rewards

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

Program Name	Program Description	Program Incentive
<b>Smart Rewards (Wellbeing Solutions Engagement Package 500)</b>	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 \$500 per member per year
<b>Gym Reimbursement</b>	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](http://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.

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

NY/SG/Anthem Gold EPO 25/50 0%/8AF8/01-01-2025

### 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:

**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) 330-1105。

**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) 330-1105 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) 330-1105.

**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) 330-1105.

**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) 330-1105.

**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) 330-1105 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) 330-1105로 문의하십시오.

**Navajo (Diné):** Dii naaltsoos biká'ígíí lahgo bina'ídiikidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj bee nił hodoonih t'áadoo bááh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih nínízingo koj' hodiłnił (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 ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਬਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (855) 330-1105 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) 330-1105.

**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) 330-1105.

**Tagalog (Tagalog):** Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (855) 330-1105.

**Vietnamese (Tiếng Việt):** Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (855) 330-1105.

### 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>.