

Virginia Private Colleges: Plan 4 PPO



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/as0>. 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/ or call (833) 597-2358 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	\$750/person or \$1,500/family for In- <u>Network Providers</u> . \$750/person or \$1,500/family for Non- <u>Network Providers</u> .	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>Preventive Care</u> for In- <u>Network Providers</u> . Vision for In- <u>Network</u> and Non- <u>Network Providers</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes. \$150/person or \$300/family for <u>Prescription Drugs</u> In- <u>Network Providers</u> . There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	\$3,250/person or \$6,500/family for In- <u>Network Providers</u> . \$4,500/person or \$9,000/family for Non- <u>Network Providers</u> . This <u>plan</u> has a separate Out of Pocket Maximum of \$3,350/person or \$6,700/family for <u>Prescription Drugs</u> In- <u>Network Providers</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	Premiums, <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network</u>?	Yes, KeyCare. See www.anthem.com or call (833)	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive

<u>provider</u> ?	597-2358 for a list of <u>network providers</u> .	a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20/visit	30% <u>coinsurance</u>	Virtual visits (Telehealth) benefits available.
	<u>Specialist</u> visit	\$40/visit	30% <u>coinsurance</u>	Virtual visits (Telehealth) benefits available.
	<u>Preventive care</u> / <u>screening</u> / <u>immunization</u>	No charge	30% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$20 PCP/\$40 Spec/visit Or 20% coinsurance in a facility setting	30% <u>coinsurance</u>	Costs may vary by site of service.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Costs may vary by site of service.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at http://www.anthem.com/pharmacyinformation/	Tier 1 - Typically Generic	\$10/prescription, Prescription Drug <u>deductible</u> does not apply (retail and home delivery)	Not covered (retail) and Not covered (home delivery)	For more information, refer to "Essential Drug List" at http://www.anthem.com/pharmacyinformation/ *See Prescription Drug section
	Tier 2 - Typically Preferred Brand & Non-Preferred Generic Drugs	Greater of \$40 or 30% <u>coinsurance</u> up to \$80/prescription, Prescription Drug <u>deductible</u> applies (retail) and Greater of \$80 or 30% <u>coinsurance</u> up to \$160/prescription, Prescription Drug <u>deductible</u> applies (home delivery)	Not covered (retail) and Not covered (home delivery)	Medications on the VPCBC Preventive Rx List are free of charge and are not subject to the deductible.
	Tier 3 - Typically Non-Preferred Brand and Generic drugs	Greater of \$60 or 40% <u>coinsurance</u> up to	Not covered (retail) and Not covered (home delivery)	

* For more information about limitations and exceptions, see plan or policy document at <https://eoc.anthem.com/eocdps/aso>.

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)	
		\$120/prescription, Prescription Drug <u>deductible</u> applies (retail) and Greater of \$120 or 40% <u>coinsurance</u> up to \$240/prescription, Prescription Drug <u>deductible</u> applies (home delivery)		Rx Maintenance 90- You may get two 30 day supply fills of the same maintenance medication at a retail pharmacy. Prior to your 3 rd fill, you must switch to home delivery.
	Tier 4 - Typically Preferred Specialty (brand and generic) (Specialty 30 day fills)	50% <u>coinsurance</u> up to \$200/prescription, Prescription Drug <u>deductible</u> applies (retail) and (home delivery)	Not covered (retail) and Not covered (home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	-----none-----
	Physician/surgeon fees	20% <u>coinsurance</u>	30% <u>coinsurance</u>	-----none-----
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	-----none-----
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	-----none-----
	<u>Urgent care</u>	\$20 PCP/\$40 Spec./visit	30% <u>coinsurance</u>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	-----none-----
	Physician/surgeon fees	20% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit \$20/visit Other Outpatient No charge	Office Visit 30% <u>coinsurance</u> Other Outpatient 30% <u>coinsurance</u>	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient -----none-----
	Inpatient services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Preauthorization
If you are pregnant	Office visits	\$20 PCP/\$40 Spec. pregnancy for the first 1 visit <u>deductible</u> does not apply.	30% <u>coinsurance</u>	One <u>copayment</u> per pregnancy for office visit services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need help recovering or	<u>Home health care</u>	No charge	30% <u>coinsurance</u>	90 visits/benefit period.

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

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)	
have other special health needs	Rehabilitation services	ST \$20 PCP/\$40 Spec/visit PT and OT \$30/visit	30% coinsurance	Costs may vary by site of service. *See Therapy Services section.
	Habilitation services	ST \$20PCP/\$40 Spec/visit PT and OT \$30/visit	30% coinsurance	
	Skilled nursing care	20% coinsurance	30% coinsurance	100 days/stay for skilled nursing services. Preauthorization.
	Durable medical equipment	20% coinsurance	30% coinsurance	*See Durable Medical Equipment Section
	Hospice services	No charge	30% coinsurance	-----none-----
If your child needs dental or eye care	Children's eye exam	\$15/visit deductible does not apply	Reimbursed Up to \$30	*See Vision Services section
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	-----none-----

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](#).)

- Acupuncture
- Dental care (Pediatric)
- Routine foot care unless [medically necessary](#)
- Cosmetic surgery
- Dental Check-up
- Infertility treatment
- Weight loss programs
- Dental care (Adult)
- Glasses for a child
- Long-term care

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

- Bariatric surgery
- Private-duty nursing 16 hours/member/benefit period Facility Setting only
- Chiropractic care 30 visits/benefit period
- Routine eye care (Adult) 1 exam/benefit period
- Hearing Aids
- Most coverage provided outside the United States. See 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, Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform, 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 or call 1-800-318-2596.

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

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 on how 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

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform

Does this plan provide Minimum Essential Coverage? Yes

[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

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 [plan](#) or policy document at <https://eoc.anthem.com/eocdps/aso>.

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 copayment](#)
- Hospital (facility) [coinsurance](#)
- Other [copayment](#)

\$750
\$40
20%
\$40

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

Deductibles	\$750
Copayments	\$400
Coinsurance	\$2,100

What isn't covered

Limits or exclusions	\$60
The total Peg would pay is	\$3,310

Managing Joe's Type 2 Diabetes

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

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

\$750
\$40
20%
\$40

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

Deductibles *	\$900
Copayments	\$200
Coinsurance	\$1,100

What isn't covered

Limits or exclusions	\$20
The total Joe would pay is	\$2,220

Mia's Simple Fracture

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

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

\$750
\$40
20%
\$40

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

Deductibles	\$750
Copayments	\$300
Coinsurance	\$200

What isn't covered

Limits or exclusions	\$0
The total Mia would pay is	\$1,250

*This plan has other deductibles for specific services included in this coverage example. See “Are there other deductibles for specific services?” row above.

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 (833) 597-2358

Amharic (አማርኛ): ከለሁ ሰነዶች ማንኛውም ብቻ ከለዋቸው ተንቁቻ እና የሆነ መረጃ በለን የማንኛውም መብት አለዋቸው:: አስተርጓሚ ለማናገር (833) 597-2358 የደጋጋሚ::

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) 597-2358 .

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՝ (833) 597-2358:

Bassa (Basa Wùqdù): M dyi dyi-diè-dé bé bédé bá céè-dé nià ke dyí ní, o mò nì dyí-bèdèin-dé bé m ké gbo-kpá-kpá kè bó kpó dé m bídí-wùqdùún bó pídyi. Bé m ké wuqu-zìin-nyò dò gbo wùqdù ke, dà (833) 597-2358.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্য সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাসীর সাথে কথা খান জন্য (833) 597-2358 -তে কল করুন।

Burmese (မြန်မာ): ဤတရုပ်တတ်မှုနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကုအညီကို အကြောင်းငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားမြန် တစ်ဦးနှင့် စကားမြန်ရန် ဖူး (833) 597-2358 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(833) 597-2358。

Dinka (Dinka): Na nɔj thiēec nē ke de yā thorē, ke yin nɔj loj bē yi kuony ku wer alēu bē geer yic yin ne thoj du ke cin wēu tāāuē ke piny. Te kɔr yin ba jam wēnē ran ye thok geryic, ke yin col (833) 597-2358.

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 (833) 597-2358.

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 (833) 597-2358 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 (833) 597-2358.

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 (833) 597-2358.

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 (833) 597-2358.

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 (833) 597-2358.

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) 597-2358.

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 (833) 597-2358 |

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 (833) 597-2358.

Igbo (Igbo): O bụr ụ na ị nwere ajụụ ọ bụla gbasara akwụkwọ a, ị nwere ikiye ịnweta enyemaka na ozi n'asụṣụ gi na akwụghị ụgwọ ọ bụla. Ka gi na ọkowa okwu kwuo okwu, kpọọ (833) 597-2358.

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 (833) 597-2358.

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 (833) 597-2358.

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 (833) 597-2358

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 (833) 597-2358 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ): បើមុកមានសំណូរឡើងទៅគម្រោគសារនេះ មុកមានសិទ្ធិទន្លេលដែនូយនិងកំមានជាការបស់មុកដោយគគិតគ្នា។
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Lao (ພາສາລາວ): ທ່ານມີຄໍາຖາມໃດໆກ່ອນກັບພາກສານນີ້, ທ່ານມີສິດໄດ້ກັບຄວາມຮ່ວມມື້ນ ແລະ ຂໍມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ແລ້ວ. ເພື່ອໄຫວ້ມີກັບໜ້າມເປັນພາສາ, ໃຫ້ໄທຫາ (833) 597-2358.

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