Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Plan: PPO 750 Out-of-Area

Your Network: KeyCare

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$750 person / $1,500 family	$2,000 person / $4,000 family
Out-of-Pocket Limit	$5,500 person / $11,000 family	$7,000 person / $14,000 family
The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum. Your copays, coinsurance, and deductible count toward your out-of-pocket amount(s). In-network and out-of-network deductible and out-of-pocket maximum amounts are separate and do not accumulate toward each other.		
Preventive Care / Screening / Immunization	No charge	50% coinsurance after medical deductible is met
Doctor Home and Office Services **Primary Care Visit**	$25 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Specialist Care Visit	$50 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prenatal and Post-natal Care *$350 global fee covers maternity ultrasounds.*	$350 global copay for all professional services medical deductible does not apply	50% coinsurance after medical deductible is met
Other Practitioner Visits:		
Retail Health Clinic	$25 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Preferred On-line Visit *Includes Mental Health and Substance Abuse* *Live Health Online is the preferred telehealth solution.* *(www.livehealthonline.com).*	$15 copay per visit medical deductible does not apply	Not Applicable
Other Participating Provider On-line Visit *Includes Mental Health and Substance Abuse*	$25 PCP/$50 SCP copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Manipulation Therapy *Coverage is limited to 30 visits per benefit period.*	$25 copay plus 15% coinsurance medical deductible does not apply	50% coinsurance after medical deductible is met
Other Services in an Office:		
Allergy Testing	15% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Chemo/Radiation/Respiratory Therapy	$50 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Dialysis/Hemodialysis	15% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Prescription Drugs – *injected / infused in the office*	No charge	50% coinsurance after medical deductible is met
Diagnostic Services **Lab:**		
Office	Included with office visit copay	50% coinsurance after medical deductible is met
Preferred Reference Lab	15% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	15% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
X-Ray:		
Office	Included with office visit copay	50% coinsurance after medical deductible is met
Outpatient Hospital	15% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Advanced Diagnostic Imaging:		
Office	15% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Hospital	15% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Emergency and Urgent Care		
Urgent Care	$50 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Emergency Room Facility Services	15% coinsurance after medical deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	15% coinsurance after medical deductible is met	Covered as In-Network
Ambulance	15% coinsurance after medical deductible is met	Covered as In-Network (Non-Emergency Ambulance covered at 50% coinsurance after medical deductible is met)
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit (includes online visits)	$25 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Facility visit:		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Facility Fees	15% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Doctor Services	$25 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	15% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Freestanding Surgical Center	15% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Doctor and Other Services:		
Office		
Primary Care Provider	$25 copay, medical deductible does not apply	50% coinsurance after medical deductible is met
Specialist	$50 copay, medical deductible does not apply	50% coinsurance after medical deductible is met
Hospital	15% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):		
Facility fees	15% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Doctor and other services	15% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Recovery & Rehabilitation **Home Health Care** *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services. Private Duty Nursing is not covered.*	0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Rehabilitation services: Office *Coverage for rehabilitative and habilitative physical therapy, occupational therapy and speech therapy is limited to 30 visits each per benefit period in network & out of network combined and office & outpatient combined.*	15% Coinsurance after medical deductible has been met	50% coinsurance after medical deductible is met
Outpatient Hospital *Coverage for rehabilitative and habilitative physical therapy, occupational therapy and speech therapy is limited to 30 visits each per benefit period in network & out of network combined and office & outpatient combined.*	15% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Cardiac and Pulmonary rehabilitation Office *Coverage for cardiac and pulmonary rehabilitation combined is limited to 30 visits each per benefit period for all places of service and in network and out of network combined.*	15% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Hospital *Coverage for cardiac and pulmonary rehabilitation combined is limited to 30 visits each per benefit period for all places of service and in network and out of network combined.*	15% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 100 days each in network and out of network combined per benefit period.*	15% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Hospice	0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Durable Medical Equipment	15% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Prosthetic Devices *Wigs are limited to one per year*	15% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out of Pocket	Combined with medical	Combined with medical
Prescription Drug Coverage *National Network* *National Direct Drug List* *No coverage for non-formulary drugs.* *R90 – 90 day retail* *Home Delivery Pharmacy – maintenance medications are available through IngenioRx Home Delivery Pharmacy. You will need to call us on the number on your ID card to sign up when you first use this service.*		
Tier 1 - Typically Generic *30 day supply (retail pharmacy). 90 day supply (retail and home delivery).*	$10 copay per prescription, deductible does not apply (retail) and $20 copay per prescription, deductible does not apply (retail and home delivery)	$10 copay per prescription, deductible does not apply (retail) and $20 copay per prescription, deductible does not apply (90 day retail) Not covered (home delivery)
Tier 2 – Typically Preferred Brand *30 day supply (retail pharmacy). 90 day supply (retail and home delivery).*	$30 copay per prescription, deductible does not apply (retail) and $60 copay per prescription, deductible does not apply (retail and home delivery)	$30 copay per prescription, deductible does not apply (retail) and $60 copay per prescription, deductible does not apply (90 day retail) Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *30 day supply (retail pharmacy). 90 day supply (retail and home delivery).*	$60 copay per prescription, deductible does not apply (retail) and $120 copay per prescription, deductible does not apply (retail and home delivery)	$60 copay per prescription, deductible does not apply (retail) and $120 copay per prescription, deductible does not apply (90 day retail) Not covered (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. Only children's vision services count towards your out of pocket limit.		
Child Vision exam *Limited to 1 exam per benefit period.*	No charge	Reimbursed Up to $30
Adult Vision exam *Limited to 1 exam per benefit period.*	$15 copay	Reimbursed Up to $30

Notes:

- Your copays, coinsurance and deductible count toward your out of pocket amount.
- The representations of benefits in this document are subject to Division of Insurance approval and are subject to change.
- If you have a visit with your Primary Care Physician, Specialist or Urgent Care at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services" which is generally coinsurance or coinsurance after your deductible is met.
  Costs may also vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.

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 to the applicable Anthem enrollment brochure.

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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) 988-2030

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) 988-2030 .

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) 988-2030:

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) 988-2030。

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 (833) 988-2030 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 (833) 988-2030.

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) 988-2030.

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) 988-2030.

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) 988-2030 にお電話ください。

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(833) 988-2030로 문의하십시오.

Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bína'idiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínízingo koji' hodíilnih (833) 988-2030.

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) 988-2030.

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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. (833) 988-2030.

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It's important we treat you fairly
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