

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Contract Code: 5VJK

Your Plan: PPO KeyCare 25 500/20%/4000 Rx \$10/\$40/\$70/20%

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
<p>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.</p>		
Preventive Care / Screening / Immunization	No charge	50% coinsurance after medical deductible is met
<u>Doctor Home and Office Services</u>		
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

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

VA/LG/Anthem KeyCare 25 500/20%/4000 Rx \$10/\$40/\$70/20%/5VJK/01-01-2021

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Prenatal and Post-natal Care <i>\$350 global fee covers maternity ultrasounds.</i></p>	<p>\$350 global copay for all professional services medical deductible does not apply</p>	<p>50% coinsurance after medical deductible is met</p>
<p><u>Other Practitioner Visits:</u></p> <p>Retail Health Clinic</p> <p>Preferred On-line Visit <i>Includes Mental Health and Substance Abuse Live Health Online is the preferred telehealth solution. www.livehealthonline.com.</i></p> <p>Other Participating Provider On-line Visit <i>Includes Mental Health and Substance Abuse</i></p> <p>Manipulation Therapy <i>Coverage is limited to 30 visits per benefit period.</i></p>	<p>\$25 copay per visit medical deductible does not apply</p> <p>\$15 copay per visit medical deductible does not apply</p> <p>\$25 PCP/\$50 SCP copay per visit medical deductible does not apply</p> <p>\$25 copay plus 15% coinsurance medical deductible does not apply</p>	<p>50% coinsurance after medical deductible is met</p> <p>Not Applicable</p> <p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>
<p><u>Other Services in an Office:</u></p> <p>Allergy Testing</p> <p>Chemo/Radiation/Respiratory Therapy</p> <p>Dialysis/Hemodialysis</p> <p>Prescription Drugs - <i>Dispensed in the office</i></p>	<p>15% coinsurance after medical deductible is met</p> <p>\$50 copay per visit medical deductible does not apply</p> <p>15% coinsurance after medical deductible is met</p> <p>15% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>
<p><u>Diagnostic Services</u> Lab:</p> <p>Office</p> <p>Preferred Reference Lab</p>	<p>Included with office visit copay</p> <p>15% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>

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 Outpatient Hospital	Included with office visit copay 15% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met 50% coinsurance after medical deductible is met
Advanced Diagnostic Imaging: Office Outpatient Hospital	15% coinsurance after medical deductible is met 15% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met 50% coinsurance after medical deductible is met
<u>Emergency and Urgent Care</u> Urgent Care	\$50 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Emergency Room Facility Services Emergency Room Doctor and Other Services	15% coinsurance after medical deductible is met 15% coinsurance after medical deductible is met	Covered as In-Network Covered as In-Network
<u>Ambulance</u>	15% coinsurance after medical deductible is met	Covered as In-Network (Non-Emergency Ambulance covered at 50% coinsurance after medical deductible is met)
<u>Outpatient Mental/Behavioral Health and Substance Abuse</u> Doctor Office Visit (includes online visits) Facility visit:	\$25 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
<p>Facility Fees</p> <p>Doctor Services</p>	<p>15% coinsurance after medical deductible is met</p> <p>\$25 copay per visit medical deductible does not apply</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>
<p><u>Outpatient Surgery</u></p> <p>Facility Fees:</p> <p>Hospital</p> <p>Freestanding Surgical Center</p> <p>Doctor and Other Services:</p> <p>Hospital</p>	<p>15% coinsurance after medical deductible is met</p> <p>15% coinsurance after medical deductible is met</p> <p>15% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>
<p><u>Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):</u></p> <p>Facility fees</p> <p>Doctor and other services</p>	<p>15% coinsurance after medical deductible is met</p> <p>15% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><u>Recovery & Rehabilitation</u></p> <p>Home Health Care <i>Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services. Private Duty Nursing is not covered.</i></p>	0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
<p>Rehabilitation services:</p> <p>Office <i>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.</i></p> <p>Outpatient Hospital <i>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.</i></p>	15% Coinsurance after medical deductible has been met	50% coinsurance after medical deductible is met
<p>Cardiac and Pulmonary rehabilitation</p> <p>Office <i>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.</i></p> <p>Outpatient Hospital <i>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.</i></p>	15% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
<p>Skilled Nursing Care (facility) <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 100 days each in network and out of network combined per benefit period.</i></p>	15% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
<p>Hospice</p>	0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
<p>Durable Medical Equipment</p>	15% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
<p>Prosthetic Devices <i>Wigs are limited to one per year</i></p>	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
<p>Prescription Drug Coverage <i>National Network with Retail 90 Maintenance</i> <i>National Direct Drug List</i> <i>This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs.</i></p>		
<p>Tier 1 - Typically Generic <i>30 day supply (retail pharmacy). 90 day supply (home delivery).</i></p>	<p>\$10 copay per prescription, deductible does not apply (retail) and \$20 copay per prescription, deductible does not apply (home delivery)</p>	<p>\$10 copay per prescription, deductible does not apply (retail) and Not covered (home delivery)</p>
<p>Tier 2 – Typically Preferred Brand <i>30 day supply (retail pharmacy). 90 day supply (home delivery).</i></p>	<p>\$30 copay per prescription, deductible does not apply (retail) and \$60 copay per prescription, deductible does not apply (home delivery)</p>	<p>\$30 copay per prescription, deductible does not apply (retail) and Not covered (home delivery)</p>
<p>Tier 3 - Typically Non-Preferred Brand <i>30 day supply (retail pharmacy). 90 day supply (home delivery).</i></p>	<p>\$60 copay per prescription, deductible does not apply (retail) and \$120 copay per prescription, deductible does not apply (home delivery)</p>	<p>\$60 copay per prescription, deductible does not apply (retail) and Not covered (home delivery)</p>

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<i>This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.</i>		
Child Vision exam <i>Limited to 1 exam per benefit period.</i>	No charge	Reimbursed Up to \$30
Adult Vision exam <i>Limited to 1 exam per benefit period.</i>	\$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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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.

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար գանգահարեք հետևյալ հեռախոսահամարով՝ (833) 592-9956:

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) 592-9956。

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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) 592-9956.

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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Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(833) 592-9956로 문의하십시오.

Language Access Services:

Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'idilkidgo ná bohónéedzą dóó bee ahóót'i' t'áa ni nizaad k'ehj bee nił hodoonih t'áadoo bąąh ilinígóó. Ata' halne'ígíí la' bich'i' hadeesdzih nínizingo koj' hodíilnih (833) 592-9956.

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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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) 592-9956.

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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>.