

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Contract Code:

Your Plan: Plan 12 PPO HSA Embedded

Your Network: KeyCare

This schedule provides just a summary of the Covered Expenses, Limitations and Exclusions under the Plan. All benefits below are subject to the Plan's terms and conditions, including Deductible and Coinsurance. In Network Discounts and Allowable Charges, as set forth in the Plan Documents to which this Schedule is attached. Please read this Schedule only in conjunction with the Plan Documents.

Benefits payable by the Plan may change depending upon whether Covered Services are obtained from a Participating Provider. The list of Participating Providers may change from time to time. A list of Participating Providers is located at <http://www.anthem.com>. Therefore, it is important to verify that the Provider who is treating you is currently a Participating Provider.

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	0% coinsurance after deductible is met
Mental Health & Substance Use Disorder Services	0% coinsurance after deductible is met
Specialist care	0% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	\$5,000 person / \$10,000 family	\$5,000 person / \$10,000 family
Overall Out-of-Pocket Limit	\$6,750 person / \$13,500 family	\$7,750 person / \$15,500 family
The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per person 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 per person deductible or per person out-of-pocket maximum. Your copays, coinsurance and deductible count toward your out of pocket amount(s). In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other.		
Doctor Visits (virtual and office) <i>You are encouraged to select a Primary Care Physician (PCP).</i>		
Primary Care (PCP) <i>virtual and office</i>	0% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Mental Health and Substance Use Disorder Services <i>virtual and office</i>	0% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Specialist Provider <i>virtual and office</i>	0% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<u>Other Practitioner Visits</u> Maternity Doctor Care Prenatal and Postpartum care Delivery Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i> Manipulation Therapy <i>Coverage is limited to 30 visits per benefit period.</i>	0% coinsurance after medical deductible is met 0% coinsurance after medical deductible is met 0% coinsurance after medical deductible is met 0% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
<u>Other Services in an Office</u> Allergy Testing Prescription Drugs <i>Dispensed in the office</i> Surgery	0% coinsurance after medical deductible is met 0% coinsurance after medical deductible is met 0% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
Preventive care / screenings / immunizations	No charge	40% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	Cost share is based on the setting services are received.
<u>Diagnostic Services Lab</u> Office	0% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Reference Lab	0% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	0% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<u>Diagnostic Services X-Ray</u>		
Office	0% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	0% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<u>Diagnostic Services Advanced Diagnostic Imaging</u> <i>for example: MRI, PET and CAT scans</i>		
Office	0% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	0% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<u>Emergency and Urgent Care</u>		
Urgent Care <i>includes doctor services. Additional charges may apply depending on the care provided.</i>	0% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Emergency Room Facility Services	0% coinsurance after medical deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	0% coinsurance after medical deductible is met	Covered as In-Network
Ambulance	0% coinsurance after medical deductible is met	Covered as In-Network
<u>Outpatient Mental Health and Substance Use Disorder Services at a Facility</u>		
Facility Fees	0% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Doctor Services	0% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<u>Outpatient Surgery</u> Facility Fees Hospital Ambulatory Surgical Center Physician and other services <i>including surgeon fees</i> Hospital	0% coinsurance after medical deductible is met 0% coinsurance after medical deductible is met 0% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
<u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u> Facility Fees Physician and other services <i>including surgeon fees</i>	0% coinsurance after medical deductible is met 0% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
<u>Home Health Care</u> <i>Coverage is limited to 90 visits per benefit period. Limits are combined for all home health services.</i>	0% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<u>Therapy Services</u> Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies.</i> <i>Coverage for physical and occupational therapies is limited to 30 visits combined per benefit period. Coverage for speech therapy is limited to 30 visits per benefit period.</i> Office Outpatient Hospital	0% coinsurance after medical deductible is met 0% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
Pulmonary rehabilitation <i>office and outpatient hospital</i>	0% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Cardiac rehabilitation <i>office and outpatient hospital</i> <i>Coverage is unlimited visits</i>	0% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Dialysis/Hemodialysis <i>office and outpatient hospital</i>	0% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Chemo/Radiation Therapy <i>office and outpatient hospital</i>	0% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Skilled Nursing Care (facility) <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 100 days combined per admission.</i>	0% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Inpatient Hospice	0% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<u>Additional Services, Equipment and Devices</u> Durable Medical Equipment	0% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prosthetic Devices <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period. Limit is combined In-Network and Non-Network.</i>	0% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Wigs <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period. Limit is combined In-Network and Non-Network.</i>	0% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Hearing Aids <i>One hearing aid per hearing impaired ear per 36 months, for adults and children, includes wearable and bone anchored hearing aids. \$2,500 benefit maximum.</i>	0% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Autism Spectrum Disorder (ASD) Therapeutic Care: unlimited physical, occupational and speech therapy.	0% of the amount the health care professionals in our network have agreed to accept for their services	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Applied Behavioral Analysis	0% of the amount the health care professionals in our network have agreed to accept for their services	40% coinsurance after medical deductible is met
Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with out of network medical deductible
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Not covered
Prescription Drug Coverage Network: Advantage Network Drug List: Essential Direct <i>Drugs not included on the Essential Direct drug list will not be covered.</i>		
Day Supply Limits: Prescription Drug Coverage <i>Cost shares for drugs included on the Essential Direct drug list appear below. Your plan uses the Advantage Network. You may receive up to a 90 day supply of medication at Rx Maintenance 90 pharmacies. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply. Drug cost share assistance programs may be available for certain specialty drugs</i> Home Delivery Pharmacy <i>90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy. You may get two 30-day supply fills of the same maintenance medication at a retail pharmacy. Prior to your 3rd fill, you must call us on the number on your ID card and tell us if you would like to keep getting your maintenance medications from a retail pharmacy or if you would like to use home delivery. If you do not contact us, you will pay the full retail cost of any maintenance medication until you inform us of your decision.</i> Specialty Pharmacy <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> Preventive Drugs <i>No deductible, copayment or coinsurance for In-Network drugs included on the VPCBC Preventive RX drug list, a designated list of drugs for the treatment of diabetes, asthma, depression, heart health, high blood pressure, high cholesterol, and osteoporosis. This list is free of charge and is not subject to the deductible.</i>		
Tier 1 Preventive - Typically Generic <i>Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy). Per 90 day supply (home delivery).</i>	No charge	Not covered (retail and home delivery)
Tier 2 Preventive - Typically Preferred Brand <i>Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).</i>	No charge	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
<i>Per 90 day supply (home delivery).</i>		
Tier 1 – Typically Generic <i>Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).</i> <i>Per 90 day supply (home delivery).</i>	\$10 copay per prescription after deductible is met (retail and home delivery)	Not covered (retail and home delivery)
Tier 2 - Typically Preferred Brand <i>Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).</i> <i>Per 90 day supply (home delivery).</i>	\$35 copay per prescription after deductible is met (retail) and \$70 copay per prescription after deductible is met (home delivery)	Not covered (retail and home delivery)
Tier 3- Typically Non-Preferred Brand <i>Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).</i> <i>Per 90 day supply (home delivery).</i>	\$55 copay per prescription after deductible is met (retail) and \$165 copay per prescription after deductible is met (home delivery)	Not covered (retail and home delivery)
Tier 4 - Typically Specialty (brand and generic) <i>Per 30 day supply (specialty pharmacy)</i>	20% coinsurance up to \$200 per prescription after deductible is met (retail) and (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
<i>This is a brief outline of your vision coverage. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out-of-pocket limit.</i>		
Children's Vision exam (up to age 19) <i>Limited to 1 exam per benefit period.</i>	\$15 copay	Reimbursed Up to \$30
Adult Vision exam (age 19 and older) <i>Limited to 1 exam per benefit period.</i>	\$15 copay	Reimbursed Up to \$30

Notes:

- The representations of benefits in this document are subject to Division of Insurance approval and are subject to change.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under “Outpatient Facility Services”.

Notes:

- The representations of benefits in this document are subject to Division of Insurance approval and are subject to change.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under “Outpatient Facility Services”.
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- All medical services subject to a coinsurance are also subject to the annual medical deductible, if deductible is applicable to plan.
- If your plan includes a hospital stay copay and you are readmitted within 72 hours of a prior admission for the same diagnosis, your hospital stay copay for your readmission is waived.
- If your plan includes out of network benefits and you use a non-participating provider, you are responsible for any difference between the covered expense and the actual non-participating provider’s charge.
- In-network preventive care is not subject to deductible, if your plan has a deductible.
- If your plan includes out of network benefits and you use a non-participating provider, you are responsible for any difference between the covered expense and the actual non-participating provider’s charge. When receiving care from providers out of network, members may be subject to balance billing in addition to any applicable copayments, coinsurance and/or deductible. This amount does not apply to the out of network out of pocket limit.
- For additional information on this plan, please visit www.sbc.anthem.com to obtain a “Summary of Benefits and Coverage”.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- Your copays, coinsurance and deductible count toward your out of pocket amount.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.

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 on limitations and exclusions that apply to our medical plans. Visit <https://www.anthemplancomparison.com/va> to access this information.

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Questions: (833)597-2358 or visit us at www.anthem.com

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We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document

Spanish

Usted tiene derecho a obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

Chinese

您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID 卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

Vietnamese

Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của tài liệu này.

Korean

귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인 이신가요? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

Tagalog

May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

Russian

У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

French Creole

Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòm nan dokiman sa a.

Arabic

لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجانًا. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضًا طلب تنسيقات أخرى لهذه الوثيقة.

French

Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

Persian

شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

Armenian

Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Դարգապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցող եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

Japanese

あなたにはあなたの言語で無料で支援を受ける権利があります。ID カードに記載されている会員サービス番号にお電話ください。視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

Italian

Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

German

Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen Formaten anfordern.

Polish

Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

Pennsylvania Dutch

Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kannscht des do Schreiwes in en differnter Weg griege so as du's besser sehne kannscht.

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or directly to 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. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit

<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>