

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Contract Code: Custom

Your Plan: Anthem KeyCare Plus 20/20%/4000 Rx \$15/\$50/\$85/20%

Your Network: KeyCare

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge
Mental Health & Substance Use Disorder Services	No charge
Specialist care	\$40 copay per visit

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	\$0 person / \$0 family	\$1,000 person / \$2,000 family
Overall Out-of-Pocket Limit	\$4,000 person / \$8,000 family	\$10,000 person / \$20,000 family

The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit.

All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit (excluding Out-of-Network Human Organ and Tissue Transplant (HOTT), Cellular and Gene Therapy services).

In-Network and Out-of-Network out-of-pocket limit amounts are separate and do not accumulate toward each other.

Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*

Preferred PCP <i>virtual and office</i> <i>(Providers reflected in our FindCare tool as: EPHC Providers)</i>	\$10 copay per visit	Not covered
Primary Care (PCP) <i>virtual and office</i>	\$20 copay per visit	30% coinsurance after medical deductible is met
Mental Health and Substance Use Disorder Services <i>virtual and office</i>	\$20 copay per visit	30% 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 Care <i>virtual and office</i>	\$40 copay per visit	30% coinsurance after medical deductible is met
<u>Other Practitioner Visits</u>		
Maternity Doctor services (prenatal/postnatal care and delivery)	\$300 copay per pregnancy	30% coinsurance after medical deductible is met
Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i>	\$20 copay per visit	30% coinsurance after medical deductible is met
Manipulation Therapy <i>Coverage is limited to 30 visits per benefit period.</i>	\$20 copay per visit	30% coinsurance after medical deductible is met
<u>Other Services in an Office</u>		
Allergy Testing	\$10 copay per visit	30% coinsurance after medical deductible is met
Prescription Drugs <i>Dispensed in the office</i>	20% coinsurance	30% coinsurance after medical deductible is met
Surgery	\$40 copay per surgery	30% coinsurance after medical deductible is met
Preventive care / screenings / immunizations	No charge	30% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	30% coinsurance after medical deductible is met
<u>Diagnostic Services</u>		
Lab		
Office	No charge	30% coinsurance after medical deductible is met
Reference Lab	No charge	30% 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
Outpatient Hospital	\$40 copay per visit	30% coinsurance after medical deductible is met
X-Ray		
Office	20% coinsurance	30% coinsurance after medical deductible is met
Outpatient Hospital	\$40 copay per visit	30% coinsurance after medical deductible is met
Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i>		
Office	20% coinsurance	30% coinsurance after medical deductible is met
Outpatient Hospital	\$300 copay per visit	30% 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>	\$40 copay per visit	30% coinsurance after medical deductible is met
Emergency Room Facility Services <i>Your copay will be waived if admitted.</i>	\$300 copay per visit	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance	Covered as In-Network
Ambulance <i>Non-emergency Out-of-Network ambulance services are limited to an Anthem maximum payment of \$50,000 per trip. The \$50,000 limit does not apply to air ambulance services.</i>	20% coinsurance	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	\$150 copay per visit	30% coinsurance after medical deductible is met
Doctor Services	\$20 copay per visit	30% 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
<u>Outpatient Surgery</u> Facility Fees Hospital Ambulatory Surgical Center Physician and other services <i>including surgeon fees</i> Hospital	 \$300 copay per visit \$300 copay per visit \$40 copay per visit	 30% coinsurance after medical deductible is met 30% coinsurance after medical deductible is met 30% coinsurance after medical deductible is met
<u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u> <i>If readmitted within 72 hours for the same condition, no additional facility copay is required. If transferred between facilities, only one copay will apply.</i> Facility Fees Physician and other services <i>including surgeon fees</i>	 \$300 copay per day to a maximum of \$1,500 per admission \$40 copay per visit	 30% coinsurance after medical deductible is met 30% coinsurance after medical deductible is met
Home Health Care <i>Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.</i>	20% coinsurance	30% coinsurance after medical deductible is met
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	 \$20 copay per visit 20% coinsurance	 30% coinsurance after medical deductible is met 30% coinsurance after medical deductible is met
Pulmonary rehabilitation		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Office	\$40 copay per visit	30% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance	30% coinsurance after medical deductible is met
Cardiac rehabilitation <i>Coverage is limited to 36 visits per benefit period.</i> Office Outpatient Hospital	\$40 copay per visit 20% coinsurance	30% coinsurance after medical deductible is met 30% coinsurance after medical deductible is met
Dialysis/Hemodialysis office and outpatient hospital	20% coinsurance	30% coinsurance after medical deductible is met
Chemo/Radiation Therapy office and outpatient hospital	20% coinsurance	30% coinsurance after medical deductible is met
Skilled Nursing Care (facility) <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.</i>	\$300 copay per day to a maximum of \$1,500 per admission	30% coinsurance after medical deductible is met
Inpatient Hospice	20% coinsurance	30% coinsurance after medical deductible is met
Durable Medical Equipment	20% coinsurance	30% coinsurance after medical deductible is met
Prosthetic Devices <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	20% coinsurance	30% 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	Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit	Combined with In-	Combined with Out-of-

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
	Network medical out-of-pocket limit	Network medical out-of-pocket limit
Prescription Drug Coverage Network: Base Network Drug List: Essential <i>Drugs not included on the Essential drug list will not be covered.</i>		
Day Supply Limits: Retail Pharmacy 30 day supply (cost shares noted below) Retail 90 Pharmacy 90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies). Home Delivery Pharmacy 90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy. Home Delivery is optional. You will need to call us on the number on your ID card to sign up when you first use the service. Specialty Pharmacy 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.		
Tier 1 - Typically Generic	\$15 copay per prescription (retail) and \$30 copay per prescription (home delivery)	30% coinsurance (retail) and Not covered (home delivery)
Tier 2 - Typically Preferred Brand	\$50 copay per prescription (retail) and \$125 copay per prescription (home delivery)	30% coinsurance (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	\$85 copay per prescription (retail) and \$213 copay per prescription (home delivery)	30% coinsurance (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	20% coinsurance up to \$300 per prescription (retail and home delivery)	30% coinsurance (retail) and Not covered (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>		

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Children's Vision exam (up to age 19) <i>Limited to 1 exam per benefit period.</i>	No charge	\$0 copayment up to plan's Maximum Allowed Amount
Adult Vision exam (age 19 and older) <i>Limited to 1 exam per benefit period.</i>	\$15 copay	Reimbursed Up to \$30

Notes:

- 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.
- 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.
- The representations of benefits in this document are subject to Virginia Bureau of Insurance (BOI) approval and are subject to change.

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) 592-9956 or visit us at www.anthem.com

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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) 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 զանգահարեք 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。

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) 592-9956 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) 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.

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) 592-9956.

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) 592-9956 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) 592-9956로 문의하십시오.

Navajo (Diné): Díí naaltsoos biká'ígíí lahgo bina'ídiłkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj bee níl hodoonih t'áadoo báąh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih nínízingo koj' hodiłnih (833) 592-9956.

Language Access Services:

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.

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 ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (833) 592-9956 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. (833) 592-9956.

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It's important we treat you fairly

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