Your summary of benefits

Anthem®

Anthem® Blue Cross and Blue Shield

Your Contract Code: 3UJH

Your Plan: Anthem KeyCare 30/1,500

Your Network: KeyCare

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$1,500 person / $3,000 family	$1,760 person / $3,520 family
Out-of-Pocket Limit	$4,500 person / $9,000 family	$5,200 person / $10,400 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.		
Preventive Care / Screening / Immunization	No charge	40% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	40% coinsurance after medical deductible is met
Virtual Care (Telemedicine / Telehealth Visits) **Virtual Visits - Online visits with Doctors who also provide services in person**		
Primary Care (PCP)	$30 copay per visit medical deductible does not apply	40% 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
Mental Health and Substance Abuse care	$30 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Specialist	$60 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Medical Chats and Virtual Visits for Primary Care *from our Online Provider K Health, its affiliated Provider groups, via our mobile app, website or Anthem-enabled device*	No charge	
Virtual Visits from Online Provider LiveHealth Online *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*		
Primary Care (PCP) and Mental Health and Substance Abuse	$5 copay per visit medical deductible does not apply	
Specialist Care	$60 copay per visit medical deductible does not apply	
Visits in an Office		
Primary Care (PCP)	$30 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Specialist Care	$60 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	$100 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Retail Health Clinic	$30 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Manipulation Therapy *Coverage is limited to 20 visits per benefit period.*	$60 copay per visit medical deductible does not apply	40% 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
Other Services in an Office		
Allergy Testing	$30 PCP/$60 Spec. copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Chemo/Radiation Therapy	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Dialysis/Hemodialysis	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prescription Drugs *Dispensed in the office*	No charge	40% coinsurance after medical deductible is met
Surgery	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Diagnostic Services		
Lab		
Office	20% coinsurance deductible does not apply	40% coinsurance after medical deductible is met
Preferred Reference Lab	20% coinsurance deductible does not apply	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance deductible does not apply	40% coinsurance after medical deductible is met
X-Ray		
Office	20% coinsurance deductible does not apply	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance deductible does not apply	40% 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
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Emergency and Urgent Care		
Urgent Care	$60 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Emergency Room Facility Services	$200 copay/visit then 20% coinsurance deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance deductible does not apply	Covered as In-Network
Ambulance	20% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse		
Doctor Office Visit	$30 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Facility Visit		
Facility Fees	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Doctor Services	20% 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 a Non-Network Provider
Outpatient Surgery		
Facility Fees		
Hospital	$200 copay/visit then 20% coinsurance deductible does not apply	40% coinsurance after medical deductible is met
Doctor and Other Services		
Hospital	20% coinsurance deductible does not apply	40% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Doctor and other services	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Rehabilitation services *Coverage for rehabilitative and habilitative physical therapy and occupational therapy limits are separate and are limited to 30 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period.*		
Office	$60 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Outpatient Hospital	20% 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 a Non-Network Provider
Cardiac rehabilitation *Coverage is limited to 36 visits per benefit period.*		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 30 days combined per admission.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Inpatient Hospice	No Charge	40% coinsurance after medical deductible is met
Durable Medical Equipment	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit	Not applicable	Not applicable
Prescription Drug Coverage *Cost shares for drugs included on the National drug list appear below. Drugs not included on the National drug list will not be covered. Your plan uses the National Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies.*		
Home Delivery Pharmacy Retail *Maintenance (Smart 90) medication are available through CarelonRx Home Delivery Pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.*		

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	The greater of $20 or 40% coinsurance up to $50 maximum coinsurance/script (retail) Smart 90 The greater of $60 or 40% coinsurance up to $125 maximum	40% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	The greater of $20 or 40% coinsurance up to $100 maximum coinsurance/script (retail) Smart 90 The greater of $60 or 40% coinsurance up to $300 maximum	40% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	The greater of $20 or 40% coinsurance up to $100 maximum coinsurance/script (retail) Smart 90 The greater of $60 or 40% coinsurance up to $300 maximum	40% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) *Per 30 day supply (specialty pharmacy).*	The greater of $20 or 40% coinsurance up to $200 maximum coinsurance/script (retail) Smart 90 The greater of $60 or 40% coinsurance up to $600 maximum	N/A – Must use CarelonRX Specialty retail participating pharmacy.

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Children's Vision (up to age 19) **Child Vision Deductible**	Not applicable	Not applicable
Vision exam *Limited to 1 exam per benefit period.*	Not Covered	Not Covered
Adult Vision (age 19 and older) **Adult Vision Deductible**	Not covered	Not covered
Vision exam *Limited to 1 exam per benefit period.*	Not covered	Not Covered

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.

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 զանգահարեք հետևյալ հեռախոսահամարով՝ (833) 592-9956:

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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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Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'idiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí łą' bich'į' hadeesdzih ninízingo kojį' 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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