Anthem

Anthem KeyCare PPO 25/750 Lynchburg City Schools 01/1/20-12/31/20

In-Network Services	You Pay
Preventive Care Services	
Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits. *During the course of a routine screening procedure, abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and *your* provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by *your* provider, which will result in a member cost share.	No cost share*
Doctor Visits	
o office visits o urgent care visits o pre- and postnatal office visits* o home visits **If your physician submits one bill for prenatal, delivery, and postnatal care, services are covered as listed below.*	**$25** for each visit to a PCP **$45** for each visit to a specialist
o online visits (https://livehealthonline.com) (does not include livehealthonline mental health/substance abuse therapist visits)	**$15** for each visit
o allergy injections o allergy serum	**$5** for each visit
o mental health and substance abuse visits	**$25** for each visit
o physical therapy visits in an office setting (30 visit limit per CY)* o occupational therapy visits in an office setting (30 visit limit per CY)* o speech therapy visits in an office setting (30 visit limit per CY)* **Limit does not apply to Autism Spectrum Disorder.*	**$45** for each visit
o spinal manipulations and other manual medical intervention visit (20 visit limit per CY)	**$45** for each visit
o emergency room ER Facility associated Professional Provider Services (ER Dr., Radiologist, Surgeon) are covered at 20% coinsurance (no deductible).	**$200** copay/visit+ **20%** no deductible) of the amount the health care professionals in our network have agreed to accept for their services
Maternity – Global billed services*	
o Ob Physician - all routine global billed prenatal, delivery and postnatal care (excluding inpatient stays)	**$100** per pregnancy
Maternity Outpatient services	
o **Outpatient Labs and X-Rays, maternity ultrasounds**	**20%** of the amount the health care professionals in our network have agreed to accept for their services (no deductible)
Other Outpatient services	
o diagnostic lab services o diagnostic x-rays	**20%** of the amount the health care professionals in our network have agreed to accept for their services (no deductible)
Outpatient Surgery (at a facility or ambulatory surgery center)	
o surgery Outpatient Surgery Facility/Ambulatory Surgery Center associated Professional Provider Services (such as Surgeon, Assistant Surgeon, Anesthesiologist) are covered at 20% coinsurance (no deductible).	**$200 copay/visit+ 20%** of the amount the health care professionals in our network have agreed to accept for their services (no deductible)

Your benefit period runs on a calendar year basis. A calendar year means your benefit period runs from January through December.

For benefits listed with specific limits all services received in the calendar year for that benefit are applied to that limit (whether received in or out-of-network).

In most of Virginia: Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Virginia, Inc. (serving Virginia excluding the city of Fairfax, the town of Vienna and the area east of State Route 123). Independent licensee of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

All Other In-Network Services	You Pay
You will pay all the costs associated with care until you have paid $750 in one calendar year. This is known as your deductible. o If two people are covered under your plan, each of you will pay the first $750 Ind. of the cost of your care ($1,500 total). o If three or more people are covered under your plan, together you will pay the first $1,500 of the cost of your care. However, the most one family member will pay is $750. **Once you reach your deductible you pay:**	
Autism Spectrum Disorder (ASD) – For children from age 2 through 10	
Diagnosis and treatment of autism spectrum disorder including: o behavioral health treatment o psychiatric care o therapeutic care** o pharmacy care o psychological care ***Unlimited physical, occupational and speech therapy.***	Member cost shares will be dependent on the services rendered.
o applied behavioral analysis o unlimited per member annual maximum	**20%** of the amount the health care professionals in our network have agreed to accept for their services
Early Intervention – For children from birth up to age 3	
o unlimited per member per calendar year up to age 3	Member cost shares will be dependent on the services rendered.
Other Outpatient Services	
o shots and therapeutic injections including infusion medications o dialysis o chemotherapy (not given orally), IV, radiation, cardiac and respiratory therapy o medical appliances, supplies and medications, o durable medical equipment o in–office surgery o ambulance travel	**20%** of the amount the health care professionals in our network have agreed to accept for their services
Other Outpatient Services	
o diabetic supplies, equipment and education	Member cost shares will be dependent on the services rendered.
Outpatient Visits in a Hospital or Facility	
o physical therapy (30 visit limit per CY)* o occupational therapy (30 visit limit per CY)* o speech therapy (30 visit limit per CY)* o partial day mental health and substance use services ***Limit does not apply to Autism Spectrum Disorder.***	**20%** of the amount the health care professionals in our network have agreed to accept for their services
Care at Home	
o home health care (100 visit limit per CY) o private duty nursing limited to 16 hours per member per calendar year* ***Since there is no network for this service, you may be billed for the difference between what we pay for this service and the amount the private duty nursing service charged.***	**20%** of the amount the health care professionals in our network have agreed to accept for their services
o hospice care	**No cost share**
Inpatient Stays in a Network Hospital or Facility	
o semi-private room, intensive care or similar unit o Physician, nursing and other medically necessary professional services in the hospital including anesthesia, surgical and maternity delivery services. o skilled nursing facility care (30 day limit per admission)	**20%** of the amount the health care professionals in our network have agreed to accept for their services

Out-of-Network Services

Using Doctors, Hospitals and Other Health Care Professionals not Contracted to Provide Benefits

It's important to remember that health care professionals not in our network can charge whatever they want for their services. If what they charge is more than the fee our network health care professionals have agreed to accept for the same service, they may bill you for the difference between the two amounts. You will pay all the costs associated with the covered services outlined in this insert until you have paid $880 in one calendar year. This is called your out-of-network deductible.

- If two people are covered under your plan, each of you will pay the first $880 of the cost of your care ($1,760 total).
- If three or more people are covered under your plan, together you will pay the first $1,760 of the cost of your care. However, the most one family member will pay is $880.

Once you have reached this amount, when you receive covered services we will pay 60% of the fee our network health care professionals have agreed to accept for the same service. You will pay the rest, including any difference between the fee our network health care professionals have agreed to accept for the same service and the amount the health care professional not in our network charges.

Out-of-Pocket Maximums

What You Will Pay for Covered Services in One Calendar Year

When using network professionals
If you are the only one covered by your plan, you will pay $4,500 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is $0, except for those services listed below that do not count toward the annual out-of-pocket maximum.*

- If two people are covered under your plan, each of you will pay $4,500 ($9,000 total).
- If three or more people are covered under your plan, together you will pay $9,000. However, no family member will pay more than $4,500 toward the limit.

When not using network professionals
If you are the only one covered by your plan, you will pay $5,200 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is $0, except for those services listed below that do not count toward the annual out-of-pocket maximum.*

- If two people are covered under your plan, each of you will pay $5,200 ($10,400 total).
- If three or more people are covered under your plan, together you will pay $10,400. However, no family member will pay more than $5,200 toward the limit.

***The following do not count toward the calendar year Medical out-of-pocket maximum:**
- your share of the cost of outpatient prescription drugs
- the cost of routine vision care
- the cost of services and supplies not covered under your benefits
- the additional amount health care professionals not in our network may bill you when their charge is more than what we pay

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 summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.