Your summary of benefits

Anthem®

Anthem® Blue Cross and Blue Shield

Your Contract Code: 5VPL

Your Plan: Anthem KeyCare 30 2500/20%/6500 Rx $15/$50/$85/20%

Your Network: KeyCare

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$2,500 person / $5,000 family	$5,000 person / $10,000 family
Out-of-Pocket Limit	$6,500 person / $13,000 family	$16,250 person / $32,500 family
The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both 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.		
Preventive Care / Screening / Immunization	No charge	40% coinsurance after medical deductible is met
Doctor Home and Office Services		
Primary Care Visit	$30 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Enhanced Personal Healthcare Provider Office Visit	$20 copay per visit medical deductible does not apply	Not Applicable
Specialist Care Visit	$50 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Prenatal and Post-natal Care	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
Other Practitioner Visits:		
Medical Chats - *within our mobile app*	No charge	Not Applicable
Retail Health Clinic	$30 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Preferred On-line Visit *Includes Mental Health and Substance Abuse* *Live Health Online is the preferred telehealth solution. (www.livehealthonline.com).*	$10 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Other Participating Provider On-line Visit *Includes Mental Health and Substance Abuse*	$30 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Manipulation Therapy *Coverage is limited to 30 visits per benefit period.*	$30 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Other Services in an Office:		
Allergy Testing	$20 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*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Diagnostic Services **Lab:**		
Office	No charge	40% coinsurance after medical deductible is met
Preferred Reference Lab	No charge	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 Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
X-Ray:		
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
Advanced Diagnostic Imaging:		
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	$50 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Emergency Room Facility Services	20% coinsurance after medical deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after medical deductible is met	Covered as In-Network
Ambulance	20% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	$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
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
Outpatient Surgery		
Facility Fees:		
Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Freestanding Surgical Center	$350 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Doctor and Other Services:		
Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental / Behavioral Health, 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:		
Office *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period.*	$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
Outpatient Hospital *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Cardiac rehabilitation Office *Coverage is limited to 36 visits per benefit period.* Outpatient Hospital *Coverage is limited to 36 visits per benefit period.*	20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met	40% 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 150 days combined per benefit period.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Hospice	20% coinsurance after medical deductible is met	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	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 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
Prescription Drug Coverage *Standard with R90* *Essential Drug List* *This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs.*		

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Tier 1 - Typically Generic *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$15 copay per prescription, deductible does not apply (retail) and $38 copay per prescription, deductible does not apply (home delivery)	40% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$50 copay per prescription, deductible does not apply (retail) and $125 copay per prescription, deductible does not apply (home delivery)	40% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$85 copay per prescription, deductible does not apply (retail) and $213 copay per prescription, deductible does not apply (home delivery)	40% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) *30 day supply (retail pharmacy). 30 day supply (home delivery).*	20% coinsurance up to $300 per prescription, deductible does not apply (retail and home delivery)	40% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

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

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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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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Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (833) 592-9956.

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (833) 592-9956.

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