Anthem Blue Cross and Blue Shield

Your Contract Code: 398U

Your Plan: Anthem KeyCare 30 1000/20%/4500

Your Network: KeyCare

*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.*

| **Covered Medical Benefits** | **Cost if you use an In-Network Provider** | **Cost if you use a Non-Network Provider** |
| --- | --- | --- |
| **Overall Deductible**  *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.* | $1,000 person / $2,000 family | $2,000 person / $4,000 family |
| **Out-of-Pocket Limit**  *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.* | $4,500 person / $9,000 family | $9,000 person / $18,000 family |
| **Preventive care/screening/immunization**  *In-network preventive care is not subject to deductible, if your plan has a deductible.* | No charge | 40% coinsurance after deductible is met |
| **Doctor Home and Office Services** |  |  |
| **Primary care visit to treat an injury or illness** | $30 copay per visit | 40% coinsurance after deductible is met |
| **Specialist care visit** | $50 copay per visit | 40% coinsurance after deductible is met |
| **Prenatal and Post-natal Care** | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Other practitioner visits:** |  |  |
| Retail health clinic | $30 copay per visit | 40% coinsurance after deductible is met |
| On-line Medical Visit  *Live Health Online is* the *preferred telehealth solutions (*[[*www.livehealthonline.com*](file:///C:/Users/ac50533/AppData/Local/Temp/109/www.livehealthonline.com)](file:///C:/Users/ac50533/AppData/Local/Temp/109/www.livehealthonline.com)*)* | $20 copay per visit | 40% coinsurance after deductible is met |
| Chiropractic services  *Coverage for In-Network Provider and Non-Network Provider combined is limited to 30 visits for Rehabilitation and Habilitative per benefit period.* | $30 copay per visit | 40% coinsurance after deductible is met |
| **Other services in an office:**  Allergy testing | $30 copay per visit | 40% coinsurance after deductible is met |
| Chemo/radiation therapy | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| Dialysis/Hemodialysis | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| Prescription drugs  *For the drugs itself dispensed in the office thru infusion/injection*. | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Diagnostic Services** |  |  |
| **Lab:**  Office | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| Preferred Reference Lab | Covered in Full | 40% coinsurance after deductible is met |
| Outpatient Hospital | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **X-ray:** |  |  |
| Office | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| Freestanding Radiology Center | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| Outpatient Hospital | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Advanced diagnostic imaging (for example, MRI/PET/CAT scans):** |  |  |
| Office | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| Freestanding Radiology Center | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| Outpatient Hospital | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Emergency and Urgent Care** |  |  |
| **Emergency room facility services** | 20% coinsurance after deductible is met | Covered as In-Network |
| **Emergency room doctor and other services** | 20% coinsurance after deductible is met | Covered as In-Network |
| **Ambulance Transportation** | 20% coinsurance after deductible is met | Covered as In-Network |
| **Urgent Care Center Office Visit** | $50 copay per visit | 40% coinsurance after deductible is met |
| **Outpatient Mental Health and Substance Use Disorder** |  |  |
| **Doctor office visit and Online Visit** | $30 copay per visit | 40% coinsurance after deductible is met |
| **Facility visit:**  Facility fees | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| Doctor Services | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Outpatient Surgery** |  |  |
| **Facility fees:** |  |  |
| Hospital | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| Freestanding Surgical Center | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Doctor and other services** |  |  |
| Surgery | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Hospital Stay (all inpatient stays including maternity, mental and substance use disorder)** |  |  |
| **Facility fees (for example, room & board)** | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Doctor and other services** | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Recovery & Rehabilitation** |  |  |
| **Home health care**  *Coverage for In-Network and Non-Network Provider combined is limited to 100 visits per benefit period. Visit limit does not apply to Home Infusion Therapy or Home Dialysis.* | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Rehabilitation services (for example, physical/speech/occupational therapy):**  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. Applies to In-Network Provider and Non-Network Provider combined. Visit limit does not apply when performed as part of Hospice, Home Health, Early Intervention or Autism services. Visit limits are combined both across outpatient and other professional visits, and in and out of network.* | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| 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. Applies to In-Network Provider and Non-Network Provider combined. Visit limit does not apply when performed as part of Hospice, Home Health, Early Intervention or Autism services. Visit limits are combined both across outpatient and other professional visits, and in and out of network.* | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Habilitation services (for example, physical/speech/occupational therapy):** |  |  |
| 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. Applies to In-Network Provider and Non-Network Provider combined. Visit limit does not apply when performed as part of Hospice, Home Health, Early Intervention or Autism services. Visit limits are combined both across outpatient and other professional visits, and in and out of network.* | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| 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. Applies to In-Network Provider and Non-Network Provider combined. Visit limit does not apply when performed as part of Hospice, Home Health, Early Intervention or Autism services. Visit limits are combined both across outpatient and other professional visits, and in and out of network.* | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Cardiac rehabilitation** |  |  |
| Office Visit | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| Outpatient hospital | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Skilled nursing care (in a facility)**  *Coverage for Inpatient rehabilitation and skilled nursing services combined In-Network Provider and Non-Network Provider combined is limited to 100 days per admission.* | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Hospice** | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Durable Medical Equipment** | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Prosthetic Devices**  *Coverage for wigs needed after cancer treatment In-Network and Non-Network Provider combined is limited to 1 unit per benefit period.* | 20% coinsurance after deductible is met | 40% coinsurance after 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 out of pocket | Combined with medical out of pocket |
| **Prescription Drug Coverage**  *Anthem Essential Drug List*  *This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.* |  |  |
| **Tier 1 - Typically Generic**  *You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Covers up to a 30 day supply (retail pharmacy). Covers up to 90 day supply (retail maintenance pharmacy) Covers up to a 90 day supply (home delivery program.) No coverage for non-formulary drugs. Note: A 90 day supply is available at retail maintenance pharmacies with a copay for each 30 day supply. Coverage is also provided at retail for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time.* | $10 copay per prescription (retail only). $25 copay per prescription (home delivery only). | 40% coinsurance (retail and home delivery). |
| **Tier 2 - Typically Preferred Brand & Non-Preferred Generics**  *You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Covers up to a 30 day supply (retail pharmacy). Covers up to 90 day supply (retail maintenance pharmacy) Covers up to a 90 day supply (home delivery program.) No coverage for non-formulary drugs. Note: A 90 day supply is available at retail maintenance pharmacies with a copay for each 30 day supply. Coverage is also provided at retail for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time.* | $40 copay per prescription (retail only). $100 copay per prescription (home delivery only). | 40% coinsurance (retail and home delivery). |
| **Tier 3 - Typically Non-Preferred Brand**  *You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Covers up to a 30 day supply (retail pharmacy). Covers up to 90 day supply (retail maintenance pharmacy) Covers up to a 90 day supply (home delivery program.) No coverage for non-formulary drugs. Note: A 90 day supply is available at retail maintenance pharmacies with a copay for each 30 day supply. Coverage is also provided at retail for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time.* | $60 copay per prescription (retail only). $150 copay per prescription (home delivery only). | 40% coinsurance (retail and home delivery). |
| **Tier 4 - Typically Preferred Specialty (brand and generic)**  *You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Covers up to a 30 day supply (retail pharmacy). Covers up to 30 day supply (home delivery program.) Note: Coverage is also provided at retail for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time. No coverage for non-formulary drugs.* | 20% coinsurance up to $250 (retail and home delivery). | 40% coinsurance (retail and 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. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail.* |  |  |
| **Child Vision exam**  *Coverage for In-Network Providers is limited to 1 exam per benefit period.* | No charge | $30 reimbursement |
| **Adult Vision exam**  *Coverage for In-Network Providers is limited to 1 exam per benefit period.* | $15 copay per visit | $30 reimbursement |

**Notes:**

* The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to 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.
* Your coinsurance, copays and deductible count toward your out of pocket amount.
* For additional information on this plan, please visit sbc.anthem.com to obtain a "Summary of Benefit Coverage".
* 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, all services with calendar/plan year limits are combined both in and out of network.
* 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 providers 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.
* Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.

# 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 (844) 682-6553.

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**(TTY/TDD: 711)**

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| .(844) 682-6553 | image13 |

**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՝ (844) 682-6553:

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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 (844) 682-6553.

**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 (844) 682-6553.

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**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: (844) 682-6553.

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