Your summary of benefits

Anthem® BlueCross and BlueShield

Your Contract Code: 429D

Your Plan: Anthem KeyCare 30 2000/20%/5500

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.*	$2,000 person / $4,000 family	$4,000 person / $8,000 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.*	$5,500 person / $11,000 family	$11,000 person / $22,000 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 medical deductible is met
Doctor Home and Office Services		
Primary Care Visit to treat an injury or illness	$30 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Specialist Care Visit	$50 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met

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Prenatal and Post-natal Care *In-Network preventive prenatal and postnatal services are covered at 100%.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Other Practitioner Visits:		
Retail Health Clinic	$30 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
On-line Medical Visit *Live Health Online is the preferred telehealth solutions. (www.livehealthonline.com).*	$20 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Chiropractic Services *Coverage for Rehabilitation and Habilitation is limited to 30 visits combined per benefit period. Limit is combined In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits.*	$30 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Other Services in an Office:		
Allergy Testing	$30 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
Hemodialysis	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prescription Drugs *For the drugs itself dispensed in the office through infusion/injection.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

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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
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 (for example, MRI/PET/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 Center Office Visit	$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

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Emergency Room Doctor and Other Services	20% coinsurance after medical deductible is met	Covered as In-Network
Ambulance Transportation	20% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder		
Doctor Office Visit and Online 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
Outpatient Surgery		
Facility Fees:		
Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Freestanding Surgical Center	20% coinsurance after medical deductible is met	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

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Hospital Stay (all Inpatient stays including Maternity, Mental and Substance Use Disorder):		
Facility fees (for example, room & board) *Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 100 days combined per admission.*	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. Limit is combined In-Network and Non-Network. Visit limit does not apply to Home Infusion Therapy or Home Dialysis.*	20% coinsurance after medical deductible is met	40% coinsurance after medical 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. Limit is combined for In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Visit limits are combined both across outpatient and other professional visits. Limit is combined for In-Network and Non-Network. Visit limit does not apply when performed as part of Hospice, Home Health, Early Intervention or Autism service.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period. Limit is combined for In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Visit limits are combined both across outpatient and other professional visits. Limit is combined for In-Network and Non-Network. Visit limit does not apply when performed as part of Hospice, Home Health, Early Intervention or Autism service.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
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. Limit is combined for In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Visit limits are combined both across outpatient and other professional visits. Limit is combined for In-Network and Non-Network. Visit limit does not apply when performed as part of Hospice, Home Health, Early Intervention or Autism service.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits combined per benefit period. Limit is combined for In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Visit limits are combined both across outpatient and other professional visits. Visit limit does not apply when performed as part of Hospice, Home Health, Early Intervention or Autism service.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Cardiac rehabilitation		
Office Visit	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 (in a facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 100 days combined per admission. Limit is combined In-Network and Non-Network.*	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

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Durable Medical Equipment	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prosthetic Devices *Coverage for wigs needed after cancer treatment is limited to 1 item per benefit period. Limit is combined In-Network and Non-Network.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Your summary of benefits

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 maximum	Combined with medical out of pocket maximum
Prescription Drug Coverage *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 *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). Coverage is also provided 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.*	$10 copay per prescription, deductible does not apply (retail) and $25 copay per prescription, deductible does not apply (home delivery)	40% coinsurance (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). Coverage is also provided 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.*	$40 copay per prescription, deductible does not apply (retail) and $100 copay per prescription, deductible does not apply (home delivery)	40% coinsurance (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). Coverage is also provided 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.*	$60 copay per prescription, deductible does not apply (retail) and $150 copay per prescription, deductible does not	40% coinsurance (retail) and Not covered (home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
	apply (home delivery)	
Tier 4 - Typically Specialty (brand and generic) *Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program). Coverage is also provided 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 per prescription (retail and home delivery)	40% coinsurance (retail) and Not covered (home delivery)

Your summary of benefits

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 and Non-Network Providers is limited to 1 exam per benefit period.*	$0 copay	Reimbursed Up to $30
Adult Vision exam *Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.*	$15 copay	Reimbursed Up to $30

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Notes:

- 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.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- 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.
- Your copays, coinsurance and deductible count toward your out of pocket amount.
- To view your prescription formulary list log on to www.anthem.com/health-insurance/customer-care/forms-library
- In-network preventive care is not subject to deductible, if you plan has a deductible.
- This plan includes Home Delivery (Mail Order). Home Delivery copays are different than the Retail Pharmacy Copays.
- 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.
- For additional information on this plan, please visit www.sbc.anthem.com to obtain a "Summary of Benefit Coverage".
- 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 Plan limits coverage of Prescription Drugs to only those listed on our Essential Drug List. The Essential Drug List includes selected Generic and Brand Name Drugs. A list of the drugs that are covered on the Essential Drug List is available at https://www.anthem.com/pharmacyinformation/
- The representations of benefits in this document are subject to Division of Insurance approval and are subject to change.

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.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ 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.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (833) 592-9956.

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.

It's important we treat you fairly
That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.