Your summary of benefits

Anthem® BlueCross and BlueShield

Your Plan: Plan 2 PPO

Your Network: KeyCare

This Schedule provides just a summary of the Covered Expenses, Limitations and Exclusions under the Plan. All benefits below are subject to the Plan's terms and conditions, including Deductibles, Coinsurance, In Network discounts and Allowable Charges, as set forth in the Plan Document to which this Schedule is attached. Please read this Schedule only in conjunction with the Plan Document.

Benefits payable by the Plan may change depending upon whether Covered Services are obtained from a Participating Provider. The list of Participating Providers may change from time to time. A list of Participating Providers is located at http://www.anthem.com. Therefore, it is important to verify that the Provider who is treating you is currently a Participating Provider.

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. Deductible is based on a calendar year and it will reset Jan. 1.*	$0 person / $0 family	$500 person / $1,000 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.*	$2,500 person / $5,000 family	$4,000 person / $8,000 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.Preventive Care for Chronic Conditions per IRS guidelines.*	No charge	30% coinsurance after medical deductible is met
Doctor Home and Office Services		
Primary Care Visit to treat an injury or illness	$25 copay per visit	30% coinsurance after medical deductible is met
Specialist Care Visit	$50 copay per visit	30% 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
Prenatal and Post-natal Care *In-Network preventive prenatal services are covered at 100%.* *Copay only applies to initial visit.*	$25 PCP/$50 Specialist copay	30% coinsurance after medical deductible is met
Other Practitioner Visits:		
Retail Health Clinic	$25 copay per visit	30% coinsurance after medical deductible is met
Preferred On-line Visit *Includes Mental Health and Substance Use Disorder* *Live Health Online is the preferred telehealth solution.* *(www.livehealthonline.com).*	$5 copay per visit	30% coinsurance after medical deductible is met
Live Health on-line Dermatology- specialty care	$50 copay per visit	30% coinsurance after medical deductible is met
Other Participating Provider On-line Visit *Includes Mental Health and Substance Use Disorder*	$25 copay per visit	30% 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. Limit is combined across professional visits and outpatient facilities.*	$25 copay per visit	30% coinsurance after medical deductible is met
Other Services in an Office:		
Allergy Testing	0% coinsurance	30% coinsurance after medical deductible is met
Chemo/Radiation Therapy	$25 PCP/$50 Specialist copay	30% coinsurance after medical deductible is met
Hemodialysis	$25 PCP/$50 Specialist copay	30% coinsurance after medical deductible is met
Prescription Drugs *For the drugs itself dispensed in the office through infusion/injection.*	$25 PCP/$50 Specialist copay	30% 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
Diagnostic Services		
Lab:		
Office	$25 PCP/$50 Specialist copay	30% coinsurance after medical deductible is met
Outpatient Hospital	No charge	30% coinsurance after medical deductible is met
X-Ray:		
Office	$25 PCP/$50 Specialist copay	30% coinsurance after medical deductible is met
Outpatient Hospital	No charge	30% coinsurance after medical deductible is met
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office	$250 copay per visit	30% coinsurance after medical deductible is met
Outpatient Hospital	$250 copay per visit	30% 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
Emergency and Urgent Care		
Urgent Care Center Office Visit	$25 PCP/$50 Specialist copay per visit	30% coinsurance after medical deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$250 copay per visit	Covered as In-Network
Emergency Room Doctor and Other Services	0% coinsurance	Covered as In-Network
Ambulance Transportation	0% coinsurance	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder		
Doctor Office Visit	$25 copay per visit	30% coinsurance after medical deductible is met
Facility visit:		
Facility Fees	$250 copay per visit	30% coinsurance after medical deductible is met
Doctor Services	$25 copay per visit	30% 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
Outpatient Surgery		
Facility Fees:		
Hospital	$250 copay per visit	30% coinsurance after medical deductible is met
Freestanding Surgical Center	$250 copay per visit	30% coinsurance after medical deductible is met
Doctor and Other Services:		
Hospital	0% coinsurance	30% coinsurance after medical deductible is met
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 benefit period. Limit is combined In-Network and Non-Network.*	$350 copay per day to a maximum of $1,750 per admission	30% coinsurance after medical deductible is met
Doctor and other services	0% coinsurance	30% 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
Recovery & Rehabilitation **Home Health Care** *Coverage is limited to 90 visits per benefit period. Limit is combined In-Network and Non-Network. Limits are combined for home health care and private duty nursing.*	0% coinsurance	30% 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. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	PT/OT $30 copay per visit. ST $25 PCP/$50 Specialist copay	30% 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. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	PT/OT $30 copay per visit. ST $50 copay per visit	30% coinsurance after medical 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. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Limit is combined across professional visits and outpatient facilities. 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.*	ance PT/OT $30 copay per visit. ST $50 copay per visit	30% 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
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. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Limit is combined across professional visits and outpatient facilities. 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.*	PT/OT $30 copay per visit. ST $25 PCP/$50 Specialist copay	30% coinsurance after medical deductible is met
Cardiac rehabilitation Office Visit *Coverage for cardiac rehabilitation is unlimited visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.*	$25 PCP/50 Specialist copay per visit	30% coinsurance after medical deductible is met
Outpatient Hospital *Coverage for cardiac rehabilitation is unlimited visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.*	0% coinsurance	30% 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 benefit period. Limit is combined In-Network and Non-Network.*	0% coinsurance	30% coinsurance after medical deductible is met
Hospice	0% coinsurance	30% coinsurance after medical deductible is met
Durable Medical Equipment	0% coinsurance	30% 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.*	0% coinsurance	30% 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
Autism Spectrum Disorder (ASD) Therapeutic Care: unlimited physical, occupational and speech therapy	**Office Visit: $25** for each to a family or general practitioner, internist or pediatrician; **$50** for each visit to a specialist; **Outpatient Facility: $50** for each visit	**30%** coinsurance after medical deductible is met
Applied Behavioral Analysis	**No cost share**	**30%** 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	$150 Individual $300 Family	Not applicable
Pharmacy Out of Pocket There is a separate out-of-pocket maximum for outpatient prescription drug cost shares.	$4,100 Individual $8,200 Family	Not applicable
Prescription Drug Coverage *National Direct Drug List* *This product has a 90-day Retail Pharmacy Network available. A 90-day supply is available at most retail pharmacies.*	Medications on the VPCBC Preventive Rx List are free of charge and are not subject to the deductible.	
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). No coverage for non-formulary drugs. 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.*	Retail (per 30-day supply): $10 copay/prescription Mail Order: $10 copay/prescription	Not covered
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). No coverage for non-formulary drugs. 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.*	Retail (per 30-day supply): 30% coinsurance with a minimum of $40 (unless cost of drug is <$40) and a maximum of $80 Mail Order: 30% coinsurance with a minimum of $80 (unless cost of drug is <$80) and a maximum of $160	Not Covered

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). No coverage for non-formulary drugs. 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.*	Retail (per 30-day supply): 40% coinsurance with a minimum of $60 (unless cost of drug is <$60) and a maximum of $120 Mail Order: 40% coinsurance with a minimum of $120 (unless cost of drug is <$120) and a maximum of $240	Not Covered
Tier 4 - Typically Specialty (brand and generic) *Covers up to a 30-day supply (retail pharmacy). No coverage for non-formulary drugs. 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.*	50% to $200 per script maximum	Not Covered

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.*	$15 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

Your summary of benefits

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.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- 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 provider's charge.
- 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 provider's 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 Benefits and Coverage".
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- Your copays, coinsurance and deductible count toward your out of pocket amount.
- Any amount you pay toward your medical deductible during the 4th quarter of each calendar year (Oct-Dec) will apply not only to your deductible for that year but will also apply to your deductible for the following year.
- Out of pocket prescription drug cost do not count towards the Medical out of pocket maximum.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.

Questions: (833) 592-9956 or visit us at www.anthem.com

VA/LG/Anthem KeyCare Plus/4JMM/01-01-2020

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.

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 ła' 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.

Your summary of benefits

Anthem® BlueCross and BlueShield

Your Plan: Plan 3 PPO

Your Network: KeyCare

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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. Deductible is based on a calendar year and it will reset Jan. 1.*	$300 person / $600 family	$500 person / $1,000 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.*	$2,000 person / $4,000 family	$4,000 person / $8,000 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible. Preventive Chronic Conditions per IRS guidelines.*	No charge	30% coinsurance after medical deductible is met
Doctor Home and Office Services		
Primary Care Visit to treat an injury or illness	20% coinsurance after medical deductible is met	30% 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
Specialist Care Visit	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Prenatal and Post-natal Care *In-Network preventive prenatal services are covered at 100%.*	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Other Practitioner Visits:		
Retail Health Clinic	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
On-line Visit *Includes Mental Health and Substance Use Disorder* *Live Health Online is the preferred telehealth solution.* *(www.livehealthonline.com).*	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Live Health On-line Dermatology-specialty care	20% coinsurance after medical deductible is met	30% 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. Limit is combined across professional visits and outpatient facilities.*	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Other Services in an Office:		
Allergy Testing	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Chemo/Radiation Therapy	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Hemodialysis	20% coinsurance after medical deductible is met	30% 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	30% 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
Diagnostic Services		
Lab:		
Office	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Preferred Reference Lab	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
X-Ray:		
Office	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	30% 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
Emergency and Urgent Care		
Urgent Care Center Office Visit	20% coinsurance after medical deductible is met	30% 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 Transportation	20% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder		
Doctor Office Visit	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Facility visit:		
Facility Fees	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Doctor Services	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Freestanding Surgical Center	20% coinsurance after medical deductible is met	30% 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
Doctor and Other Services:		
Hospital	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
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 benefit period. Limit is combined In-Network and Non-Network.*	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Doctor and other services	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 90 visits per benefit period. Limit is combined In-Network and Non-Network. Limits are combined for home health care and private duty nursing.*	20% coinsurance after medical deductible is met	30% 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. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	20% coinsurance after medical deductible is met	30% 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. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits*	20% coinsurance after medical deductible is met	30% 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
per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.		
Habitation 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. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Limit is combined across professional visits and outpatient facilities. 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	30% 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. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Limit is combined across professional visits and outpatient facilities. 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	30% coinsurance after medical deductible is met
Cardiac rehabilitation		
Office Visit *Coverage for cardiac rehabilitation is unlimited visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.*	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Outpatient Hospital *Coverage for cardiac rehabilitation is unlimited visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.*	20% coinsurance after medical deductible is met	30% 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	30% 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
Hospice	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Durable Medical Equipment	20% coinsurance after medical deductible is met	30% 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	30% coinsurance after medical deductible is met
Autism Spectrum Disorder (ASD) Therapeutic Care: unlimited physical, occupational and speech therapy Applied Behavioral Analysis	**Office Visit: 20%** (after meeting deductible) **Outpatient Facility: 20%** (after meeting deductible) **20%** (after meeting deductible)	**30%** coinsurance after medical deductible is met **30%** 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 There is a separate out-of-pocket maximum for outpatient prescription drug cost shares.	$4,600 Individual $9,200 Family	Not applicable
Prescription Drug Coverage *National Direct Drug List* *This product has a 90-day Retail Pharmacy Network available. A 90-day supply is available at most retail pharmacies.*	Medications on the VPCBC Preventive Rx List are free of charge and are not subject to the deductible.	
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). No coverage for non-formulary drugs. 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.*	Retail (per 30-day supply): $10 copay/ prescription Mail Order:$10 copay/prescription	Not covered
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). No coverage for non-formulary drugs. 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.*	Retail (per 30-day supply): 30% coinsurance with a minimum of $40 (unless cost of drug is <$40) and a maximum of $80 Mail Order: 30% coinsurance with a minimum of $80 (unless cost of drug is <$80) and a maximum of $160	Not Covered

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). No coverage for non-formulary drugs. 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.*	Retail (per 30-day supply): 40% coinsurance with a minimum of $60 (unless cost of drug is <$60) and a maximum of $120 Mail Order: 40% coinsurance with a minimum of $120 (unless cost of drug is <$120) and a maximum of $240	Not Covered
Tier 4 - Typically Specialty (brand and generic) *Covers up to a 30-day supply (retail pharmacy). No coverage for non-formulary drugs. 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.*	50% to $200 per script maximum	Not Covered

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.*	$15 copay Deductible does not apply	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 Deductible does not apply	Reimbursed Up to $30

Your summary of benefits

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.
- 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 provider's charge.
- 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 provider's 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 Benefits and Coverage".
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- Your copays, coinsurance and deductible count toward your out of pocket amount.
- Any amount you pay toward your medical deductible during the 4th quarter of each calendar year (Oct-Dec) will apply not only to your deductible for that year but will also apply to your deductible for the following year.
- Out of pocket prescription drug cost do not count towards the Medical out of pocket maximum.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.

Questions: (833) 592-9956 or visit us at www.anthem.com

VA/LG/Anthem KeyCare 4JLA/01-01-2020

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 9956-592 (833) .

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 9956-592 (833) 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.

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 ła' 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.

Your summary of benefits

Anthem® BlueCross and BlueShield
Your Plan: PPO Plan 4
Your Network: KeyCare

This Schedule provides just a summary of the Covered Expenses, Limitations and Exclusions under the Plan. All benefits below are subject to the Plan's terms and conditions, including Deductibles, Coinsurance, In Network discounts and Allowable Charges, as set forth in the Plan Document to which this Schedule is attached. Please read this Schedule only in conjunction with the Plan Document.

Benefits payable by the Plan may change depending upon whether Covered Services are obtained from a Participating Provider. The list of Participating Providers may change from time to time. A list of Participating Providers is located at http://www.anthem.com. Therefore, it is important to verify that the Provider who is treating you is currently a Participating Provider.

Deductible does not apply to copay services and preventive services.

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. Deductible is based on a calendar year and it will reset Jan. 1.*	$750 person / $1,500 family	$750 person / $1,500 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. OOP is based on a calendar year and it will reset Jan. 1.*	$3,250 person / $6,500 family	$4,500 person / $9,000 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible. Preventive Chronic Conditions per IRS guidelines.*	No charge	30% coinsurance after medical deductible is met
Doctor Home and Office Services		
Primary Care Visit to treat an injury or illness	$20 copay/visit	30% coinsurance after medical deductible is met
Specialist Care Visit	$40 copay/visit	30% 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
Prenatal and Post-natal Care *In-Network preventive prenatal services are covered at 100%.* *Copay only applies to initial visit.*	$20 PCP copay/$40 Specialist copay	30% coinsurance after medical deductible is met
Other Practitioner Visits:		
Retail Health Clinic	$20 copay/visit	30% coinsurance after medical deductible is met
On-line Visit *Includes Mental Health and Substance Use Disorder* *Live Health Online is the preferred telehealth solution.* *(www.livehealthonline.com).*	$5 copay/visit	30% coinsurance after medical deductible is met
Live Health On-line Dermatology-specialty care	$40 copay/visit	
Chiropractic Services *Coverage for Rehabilitation and Habilitation is limited to 30 visits combined per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	$40 copay/visit	30% coinsurance after medical deductible is met
Other Services in an Office:		
Allergy Testing	$20 PCP/$40 Specialist copay/visit	30% coinsurance after medical deductible is met
Chemo/Radiation Therapy	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Hemodialysis	20% coinsurance after medical deductible is met	30% 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	30% 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
Diagnostic Services		
Lab:		
Office	$20 PCP/$40 Specialist copay	30% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
X-Ray:		
Office	$20 PCP/$40 Specialist copay	30% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	30% 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
Emergency and Urgent Care		
Urgent Care Center Office Visit	$20 PCP/$40 Specialist copay/visit	30% 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 Transportation	20% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder		
Doctor Office Visit	$20 copay office visit. $5 copay for online visits.	30% coinsurance after medical deductible is met
Facility visit:		
Facility Fees	0% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Doctor Services	0% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Freestanding Surgical Center	20% coinsurance after medical deductible is met	30% 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
Doctor and Other Services:		
Hospital	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
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. Limit is combined In-Network and Non-Network.*	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Doctor and other services	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 90 visits per benefit period. Limit is combined In-Network and Non-Network. Limits are combined for home health care and private duty nursing.*	No charge	30% 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. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	PT/OT -$30 copay / visit ST- $20 PCP/$40 Specialist copay	30% 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. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits*	PT/OT -$30 copay / visit ST- $20 PCP/$40 Specialist copay	30% 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
per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.		
Habitation 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. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Limit is combined across professional visits and outpatient facilities. 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.*	PT/OT -$30 copay / visit ST- $20 PCP/$40 Specialist copay	30% 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. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Limit is combined across professional visits and outpatient facilities. 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.*	PT/OT -$30 copay / visit ST- $20 PCP/$40 Specialist copay	30% coinsurance after medical deductible is met
Cardiac rehabilitation		
Office Visit *Coverage for cardiac rehabilitation is unlimited visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.*	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Outpatient Hospital *Coverage for cardiac rehabilitation is unlimited visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.*	20% coinsurance after medical deductible is met	30% 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	30% 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
Hospice	No charge	30% coinsurance after medical deductible is met
Durable Medical Equipment	20% coinsurance after medical deductible is met	30% 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	30% 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
Autism Spectrum Disorder (ASD) Therapeutic Care: unlimited physical, occupational and speech therapy.	**Office Visit: $20** for each visit to a family or general practitioner, internist or pediatrician; **$40** for each visit to a specialist (deductible does not apply) **Outpatient Facility: $40** for each visit to a specialist (deductible does not apply)	30% coinsurance after medical deductible is met
Autism Spectrum Disorder (ASD) Applied Behavioral Analysis	No charge (deductible does not apply)	30% 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	$150 Individual $300 Family	Not applicable
Pharmacy Out of Pocket There is a separate out-of-pocket maximum for outpatient prescription drug cost shares.	$3,350 Individual $6,700 Family	Not applicable
Prescription Drug Coverage *National Direct Drug List* *This product has a 90-day Retail Pharmacy Network available. A 90-day supply is available at most retail pharmacies.*	Medications on the VPCBC Preventive Rx List are free of charge and are not subject to the deductible.	
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). No coverage for non-formulary drugs. 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.*	Retail (per 30-day supply): $10 copay/ prescription Mail Order**:** $10 copay/ prescription	Not covered
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). No coverage for non-formulary drugs. 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.*	Retail (per 30-day supply): 30% coinsurance with a minimum of $40 (unless cost of drug is < $40) and a maximum of $80; Mail Order**:** 30% coinsurance with a minimum of $80 (unless cost of drug is < $80) and a maximum of $160	Not Covered

Your summary of benefits

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). No coverage for non-formulary drugs. 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.*	Retail(per 30-day supply): 40% coinsurance with a minimum of $60 (unless cost of drug is < $60) and a maximum of $120 Mail Order**:** 40% coinsurance with a minimum of $120 (unless cost of drug is <$120) and a maximum of $240	Not Covered
Tier 4 - Typically Specialty (brand and generic) *Covers up to a 30-day supply (retail pharmacy). No coverage for non-formulary drugs. 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.*	50% to $200 per script maximum	Not Covered

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.*	$15 copay Deductible does not apply.	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 Deductible does not apply.	Reimbursed Up to $30

Your summary of benefits

Notes:

- 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.
- 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 and you use a non-participating provider, you are responsible for any difference between the covered expense and the actual non-participating provider's charge.
- 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 provider's 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 Benefits and Coverage".
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- Your copays, coinsurance and deductible count toward your out of pocket amount.
- Any amount you pay toward your medical deductible during the 4th quarter of each calendar year (Oct-Dec) will apply not only to your deductible for that year but will also apply to your deductible for the following year.
- Out of pocket prescription drug cost do not count towards the Medical out of pocket maximum.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.

Questions: (833) 592-9956 or visit us at www.anthem.com

VA/LG/Anthem KeyCare 4JL8/01-01-2020

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.

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 ła' 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.

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.

Your summary of benefits

Anthem® BlueCross and BlueShield

Your Plan: Plan 5 PPO

Your Network: KeyCare

This Schedule provides just a summary of the Covered Expenses, Limitations and Exclusions under the Plan. All benefits below are subject to the Plan's terms and conditions, including Deductibles, Coinsurance, In Network discounts and Allowable Charges, as set forth in the Plan Document to which this Schedule is attached. Please read this Schedule only in conjunction with the Plan Document.

Benefits payable by the Plan may change depending upon whether Covered Services are obtained from a Participating Provider. The list of Participating Providers may change from time to time. A list of Participating Providers is located at http://www.anthem.com. Therefore, it is important to verify that the Provider who is treating you is currently a Participating Provider.

Deductible does not apply to copay services and preventive services.

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. Deductible is based on a calendar year and it will reset Jan. 1.*	$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.*	$4,000 person / $8,000 family	$6,000 person / $12,000 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible. Preventive Care for Chronic Conditions per IRS guidelines.*	No charge	40% coinsurance after medical deductible is met
Doctor Home and Office Services		
Primary Care Visit to treat an injury or illness	$20 copay per visit	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
Specialist Care Visit	$40 copay per visit	40% coinsurance after medical deductible is met
Prenatal and Post-natal Care *In-Network preventive prenatal services are covered at 100%.* *Copay only applies to initial visit.*	$20 PCP/$40 Specialist copay	40% coinsurance after medical deductible is met
Other Practitioner Visits:		
Retail Health Clinic	$20 copay /visit.	40% coinsurance after medical deductible is met
On-line Visit *Includes Mental Health and Substance Use Disorder* *Live Health Online is the preferred telehealth solution.* *(www.livehealthonline.com).*	$5 copay / visit	40% coinsurance after medical deductible is met
Live Health On-line Dermatology-specialty care	$40 copay/ visit	
Chiropractic Services *Coverage for Rehabilitation and Habilitation is limited to 30 visits combined per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	$20 PCP/$40 Specialist copay/ visit	40% coinsurance after medical deductible is met
Other Services in an Office:		
Allergy Testing	$20 PCP/$40 Specialist copay per visit	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

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Diagnostic Services		
Lab:		
Office	$20 PCP/$40 specialist copay per visit	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 PCP/$40 specialist copay per visit	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

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency and Urgent Care		
Urgent Care Center Office Visit	$20 PCP/$40 Specialist copay per visit	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 Transportation	20% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder		
Doctor Office Visit	$20 copay per visit.	40% coinsurance after medical deductible is met
Facility visit:		
Facility Fees	0% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Doctor Services	0% coinsurance after medical deductible is me	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

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Doctor and Other Services:		
Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
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. Limit is combined In-Network and Non-Network.*	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 90 visits per benefit period. Limit is combined In-Network and Non-Network. Limits are combined for home health care and private duty nursing.*	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. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	PT/OT $30 copay/visit. ST $20 PCP/ $40 Specialist copay/visit.	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. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits*	PT/OT $30 copay/visit. ST $40 Specialist copay/visit	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
per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.		
Habitation 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. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Limit is combined across professional visits and outpatient facilities. 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.*	PT/OT $30 copay/visit. ST $20 PCP/ $40 Specialist copay/visit	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. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Limit is combined across professional visits and outpatient facilities. 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.*	PT/OT $30 copay/visit. ST $40 Specialist copay/visit	40% coinsurance after medical deductible is met
Cardiac rehabilitation		
Office Visit *Coverage for cardiac rehabilitation is unlimited visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital *Coverage for cardiac rehabilitation is unlimited visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.*	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

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
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 *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
Autism Spectrum Disorder (ASD) Therapeutic Care: unlimited physical, occupational and speech therapy	**Office Visit: $20 copay** for each visit to a family or general practitioner, internist or pediatrician; **$40 copay** for each visit to a specialist; **Outpatient Facility: $40 copay** for each visit	**40% coinsurance** after medical deductible is met
Applied Behavioral Analysis	**20% coinsurance** after deductible	**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 There is a separate out-of-pocket maximum for outpatient prescription drug cost shares.	$2,600 Individual $5,200 Family	Not applicable
Prescription Drug Coverage *National Direct Drug List* *This product has a 90-day Retail Pharmacy Network available. A 90-day supply is available at most retail pharmacies.*	Medications on the VPCBC Preventive Rx List are free of charge and are not subject to the deductible.	
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). No coverage for non-formulary drugs. 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.*	Retail (per 30-day supply): $10 copay/prescription Mail Order: $10 copay/prescription	Not covered
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). No coverage for non-formulary drugs. 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.*	Retail (per 30-day supply): 30% coinsurance with a minimum of $40 (unless cost of drug is <$40) and a maximum of $80 Mail Order: 30% coinsurance with a minimum of $80 (unless cost of drug is <$80) and a maximum of $160	Not Covered

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). No coverage for non-formulary drugs. 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.*	Retail (per 30-day supply): 40% coinsurance with a minimum of $60 (unless cost of drug is <$60) and a maximum of $120 Mail Order: 40% coinsurance with a minimum of $120 (unless cost of drug is <$120) and a maximum of $240	Not Covered
Tier 4 - Typically Specialty (brand and generic) *Covers up to a 30-day supply (retail pharmacy). No coverage for non-formulary drugs. 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.*	50% to $200 per script maximum	Not Covered

Your summary of benefits

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
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Child Vision exam *Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.*	$15 copay Deductible does not apply	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 Deductible does not apply	Reimbursed Up to $30

Your summary of benefits

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.
- 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 provider's charge.
- 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 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 provider's 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 Benefits and Coverage.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- Your copays, coinsurance and deductible count toward your out of pocket amount.
- Any amount you pay toward your medical deductible during the 4th quarter of each calendar year (Oct-Dec) will apply not only to your deductible for that year but will also apply to your deductible for the following year.
- Out of pocket prescription drug cost do not count towards the Medical out of pocket maximum.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.

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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.

Your summary of benefits

Anthem

Anthem® BlueCross and BlueShield

Your Plan: Plan 6 PPO HRA Non-Embedded

Your Network: KeyCare

This Schedule provides just a summary of the Covered Expenses, Limitations and Exclusions under the Plan. All benefits below are subject to the Plan's terms and conditions, including Deductibles, Coinsurance, In Network discounts and Allowable Charges, as set forth in the Plan Document to which this Schedule is attached. Please read this Schedule only in conjunction with the Plan Document.

Benefits payable by the Plan may change depending upon whether Covered Services are obtained from a Participating Provider. The list of Participating Providers may change from time to time. A list of Participating Providers is located at http://www.anthem.com. Therefore, it is important to verify that the Provider who is treating you is currently a Participating Provider.

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. Deductible is based on a calendar year and it will reset Jan. 1.*	$1,500 person / $3,000 family	$1,500 person / $3,000 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.*	$3,000 person / $6,000 family	$4,000 person / $8,000 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible. Preventive Chronic Conditions Per IRS guidelines.*	No charge	30% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit to treat an injury or illness	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Specialist Care Visit	20% coinsurance after deductible is met	30% coinsurance after 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
Prenatal and Post-natal Care *In-Network preventive prenatal services are covered at 100%.*	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	20% coinsurance after deductible is met	30% coinsurance after deductible is met
On-line Visit *Includes Mental Health and Substance Use Disorder* *Live Health Online is the preferred telehealth solution.* *(www.livehealthonline.com).*	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Live Health Online Dermatology-specialty care	20% coinsurance after deductible is met	30% coinsurance after 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. Limit is combined across professional visits and outpatient facilities.*	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Other Services in an Office:		
Allergy Testing	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Hemodialysis	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Prescription Drugs *For the drugs itself dispensed in the office through infusion/injection.*	20% coinsurance after deductible is met	30% coinsurance after 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
Diagnostic Services		
Lab:		
Office	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Preferred Reference Lab	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	30% coinsurance after deductible is met
X-Ray:		
Office	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	30% coinsurance after 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
Emergency and Urgent Care		
Urgent Care Center Office Visit	20% coinsurance after deductible is met	30% coinsurance after deductible is met
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
Outpatient Mental Health and Substance Use Disorder		
Doctor Office Visit	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Facility visit:		
Facility Fees	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	30% coinsurance after 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
Doctor and Other Services:		
Hospital	20% coinsurance after deductible is met	30% coinsurance after deductible is met
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 benefit period. Limit is combined In-Network and Non-Network.*	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 90 visits per benefit period. Limit is combined In-Network and Non-Network. Limits are combined for home health care and private duty nursing.*	20% coinsurance after deductible is met	30% 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. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	20% coinsurance after deductible is met	30% 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. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits*	20% coinsurance after deductible is met	30% coinsurance after 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
per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.		
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. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Limit is combined across professional visits and outpatient facilities. 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 deductible is met	30% coinsurance after 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. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Limit is combined across professional visits and outpatient facilities. 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 deductible is met	30% coinsurance after deductible is met
Cardiac rehabilitation		
Office Visit *Coverage for cardiac rehabilitation is unlimited visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.*	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital *Coverage for cardiac rehabilitation is unlimited visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.*	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Skilled Nursing Care (in a facility)	20% coinsurance after deductible is met	30% coinsurance after 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
Coverage for Inpatient rehabilitation and skilled nursing services is limited to 100 days combined per admission. Limit is combined In-Network and Non-Network.		
Hospice	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Durable Medical Equipment	20% coinsurance after deductible is met	30% coinsurance after 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 deductible is met	30% coinsurance after deductible is met
Autism Spectrum Disorder (ASD) Therapeutic Care: unlimited physical, occupational and speech therapy	**20%** of the amount the health care professionals in our network have agreed to accept for their services	**30%** coinsurance after medical deductible is met
Applied Behavioral Analysis	**20%** of the amount the health care professionals in our network have agreed to accept for their services	**30%** 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	Combined with medical deductible.	Not applicable
Pharmacy Out of Pocket Coinsurance applies AFTER the deductible. Pharmacy member cost shares count towards the Medical out-of-pocket maximum.	Combined with medical out of pocket.	Not applicable
Prescription Drug Coverage *National Direct Drug List* *This product has a 90-day Retail Pharmacy Network available. A 90-day supply is available at most retail pharmacies.*	Medications on the VPCBC Preventive Rx List are free of charge and are not subject to the deductible.	
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). No coverage for non-formulary drugs. 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.*	20% coinsurance After deductible is met.	Not covered
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). No coverage for non-formulary drugs. 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.*	20% coinsurance After deductible is met.	Not Covered

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). No coverage for non-formulary drugs. 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.*	20% coinsurance After deductible is met.	Not Covered
Tier 4 - Typically Specialty (brand and generic) *Covers up to a 30-day supply (retail pharmacy). No coverage for non-formulary drugs. 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.*	20% coinsurance After deductible is met.	Not Covered

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.*	$15 copay Deductible does not apply	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 Deductible does not apply	Reimbursed Up to $30

Your summary of benefits

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.
- 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 provider's charge.
- 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 provider's 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 Benefits and Coverage".
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- Your copays, coinsurance and deductible count toward your out of pocket amount.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.

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Your summary of benefits

Anthem® BlueCross and BlueShield

Your Plan: Plan 6 PPO HSA Non-Embedded

Your Network: KeyCare

This Schedule provides just a summary of the Covered Expenses, Limitations and Exclusions under the Plan. All benefits below are subject to the Plan's terms and conditions, including Deductibles, Coinsurance, In Network discounts and Allowable Charges, as set forth in the Plan Document to which this Schedule is attached. Please read this Schedule only in conjunction with the Plan Document.

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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. Deductible is based on a calendar year and it will reset Jan. 1.*	$1,500 person / $3,000 family	$1,500 person / $3,000 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.*	$3,000 person / $6,000 family	$4,000 person / $8,000 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible. Preventive Chronic Conditions Per IRS guidelines.*	No charge	30% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit to treat an injury or illness	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Specialist Care Visit	20% coinsurance after deductible is met	30% coinsurance after 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
Prenatal and Post-natal Care *In-Network preventive prenatal services are covered at 100%.*	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	20% coinsurance after deductible is met	30% coinsurance after deductible is met
On-line Visit *Includes Mental Health and Substance Use Disorder* *Live Health Online is the preferred telehealth solution.* *(www.livehealthonline.com).* *Live Health On-line Dermatology-specialty care*	20% coinsurance after deductible is met 20% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after 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. Limit is combined across professional visits and outpatient facilities.*	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Other Services in an Office:		
Allergy Testing	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Hemodialysis	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Prescription Drugs *For the drugs itself dispensed in the office through infusion/injection.*	20% coinsurance after deductible is met	30% coinsurance after 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
Diagnostic Services		
Lab:		
Office	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Preferred Reference Lab	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	30% coinsurance after deductible is met
X-Ray:		
Office	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	30% coinsurance after 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
Emergency and Urgent Care		
Urgent Care Center Office Visit	20% coinsurance after deductible is met	30% coinsurance after deductible is met
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
Outpatient Mental Health and Substance Use Disorder		
Doctor Office Visit	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Facility visit:		
Facility Fees	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	30% coinsurance after 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
Doctor and Other Services:		
Hospital	20% coinsurance after deductible is met	30% coinsurance after deductible is met
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 benefit period. Limit is combined In-Network and Non-Network.*	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 90 visits per benefit period. Limit is combined In-Network and Non-Network. Limits are combined for home health care and private duty nursing.*	20% coinsurance after deductible is met	30% 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. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	20% coinsurance after deductible is met	30% 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. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits*	20% coinsurance after deductible is met	30% coinsurance after 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
per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.		
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. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Limit is combined across professional visits and outpatient facilities. 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 deductible is met	30% coinsurance after 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. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Limit is combined across professional visits and outpatient facilities. 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 deductible is met	30% coinsurance after deductible is met
Cardiac rehabilitation		
Office Visit *Coverage for cardiac rehabilitation is unlimited visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.*	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital *Coverage for cardiac rehabilitation is unlimited visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.*	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Skilled Nursing Care (in a facility)	20% coinsurance after deductible is met	30% coinsurance after 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
Coverage for Inpatient rehabilitation and skilled nursing services is limited to 100 days combined per admission. Limit is combined In-Network and Non-Network.		
Hospice	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Durable Medical Equipment	20% coinsurance after deductible is met	30% coinsurance after 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 deductible is met	30% coinsurance after deductible is met
Autism Spectrum Disorder (ASD) Therapeutic Care: unlimited physical, occupational and speech therapy	**20%** of the amount the health care professionals in our network have agreed to accept for their services	**30%** coinsurance after medical deductible is met
Applied Behavioral Analysis	**20%** of the amount the health care professionals in our network have agreed to accept for their services	**30%** 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	Combined with medical deductible.	Not applicable
Pharmacy Out of Pocket Coinsurance applies AFTER the deductible. Pharmacy member cost shares count towards the Medical out-of-pocket maximum.	Combined with medical out of pocket.	Not applicable
Prescription Drug Coverage *National Direct Drug List* *This product has a 90-day Retail Pharmacy Network available. A 90-day supply is available at most retail pharmacies.*	Medications on the VPCBC Preventive Rx List are free of charge and are not subject to the deductible.	
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). No coverage for non-formulary drugs. 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.*	20% coinsurance After deductible is met.	Not covered
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). No coverage for non-formulary drugs. 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.*	20% coinsurance After deductible is met.	Not Covered

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). No coverage for non-formulary drugs. 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.*	20% coinsurance After deductible is met.	Not Covered
Tier 4 - Typically Specialty (brand and generic) *Covers up to a 30-day supply (retail pharmacy). No coverage for non-formulary drugs. 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.*	20% coinsurance After deductible is met.	Not Covered

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.*	$15 copay Deductible does not apply	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 Deductible does not apply	Reimbursed Up to $30

Your summary of benefits

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.
- 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 provider's charge.
- 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 provider's 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 Benefits and Coverage".
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- Your copays, coinsurance and deductible count toward your out of pocket amount.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.

Questions: (833) 592-9956 or visit us at www.anthem.com

VA/LG/Anthem HSA 4JLZ/01-01-2020

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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 9956-592 (833) 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。

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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 ła' bich'į' hadeesdzih ninízingo kojį' hodíilnih (833) 592-9956.

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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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Your summary of benefits

Anthem® BlueCross and BlueShield

Your Plan: Plan 7 PPO HRA (Embedded Deductible)

Your Network: KeyCare

This Schedule provides just a summary of the Covered Expenses, Limitations and Exclusions under the Plan. All benefits below are subject to the Plan's terms and conditions, including Deductibles, Coinsurance, In Network discounts and Allowable Charges, as set forth in the Plan Document to which this Schedule is attached. Please read this Schedule only in conjunction with the Plan Document.

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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. See Prescription Drug Coverage section. Deductible is based on calendar year and will reset Jan. 1.*	$3,000 person / $6,000 family	$3,000 person / $6,000 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.*	$3,000 person / $6,000 family	$6,000 person / $12,000 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible. Preventive Chronic Conditions Per IRS guidelines.*	No charge	40% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit to treat an injury or illness	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Specialist Care Visit	0% coinsurance after deductible is met	40% coinsurance after 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
Prenatal and Post-natal Care *In-Network preventive prenatal services are covered at 100%.*	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	0% coinsurance after deductible is met	40% coinsurance after deductible is met
On-line Visit *Includes Mental Health and Substance Use Disorder* *Live Health Online is the preferred telehealth solution.* *(www.livehealthonline.com).* *Live Health On-line Dermatology-specialty care*	0% coinsurance after deductible is met 0% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after 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. Limit is combined across professional visits and outpatient facilities.*	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Other Services in an Office:		
Allergy Testing	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Chemo/Radiation Therapy	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Hemodialysis	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Prescription Drugs *For the drugs itself dispensed in the office through infusion/injection.*	0% coinsurance after deductible is met	40% coinsurance after 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
Diagnostic Services		
Lab:		
Office	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Preferred Reference Lab	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	40% coinsurance after deductible is met
X-Ray:		
Office	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	40% coinsurance after 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
Emergency and Urgent Care		
Urgent Care Center Office Visit	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Emergency Room Facility Services	0% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	0% coinsurance after deductible is met	Covered as In-Network
Ambulance Transportation	0% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder		
Doctor Office Visit	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Facility visit:		
Facility Fees	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor Services	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Surgical Center	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor and Other Services:		

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Hospital	0% 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) *Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 100 days combined per admission. Limit is combined In-Network and Non-Network.*	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor and other services	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 90 visits per benefit period. Limit is combined In-Network and Non-Network. Limits are combined for home health care and private duty nursing.*	0% 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. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	0% 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. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Limit is combined for In-Network and Non-*	0% coinsurance after deductible is met	40% coinsurance after 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
Network. Limit is combined across professional visits and outpatient facilities.		
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. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Limit is combined across professional visits and outpatient facilities. 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.*	0% 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 combined per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Limit is combined across professional visits and outpatient facilities. 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.*	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Cardiac rehabilitation		
Office Visit *Coverage for cardiac rehabilitation is unlimited visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.*	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital *Coverage for cardiac rehabilitation is unlimited visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.*	0% 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 is limited to 100 days combined per admission. Limit is combined In-Network and Non-Network.*	0% coinsurance after deductible is met	40% coinsurance after 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
Hospice	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Durable Medical Equipment	0% coinsurance after deductible is met	40% coinsurance after 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.*	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Autism Spectrum Disorder (ASD) Therapeutic Care: unlimited physical, occupational and speech therapy	**0%** of the amount the health care professionals in our network have agreed to accept for their services	**40%** coinsurance after medical deductible is met
Applied Behavioral Analysis	**0%** of the amount the health care professionals in our network have agreed to accept for their services	**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	Combined with medical deductible.	Not applicable
Pharmacy Out of Pocket Coinsurance applies AFTER the deductible. Pharmacy member cost shares count towards the Medical out-of-pocket maximum.	Combined with medical out of pocket.	Not applicable
Prescription Drug Coverage *National Direct Drug List* *This product has a 90-day Retail Pharmacy Network available. A 90-day supply is available at most retail pharmacies.*	Medications on the VPCBC Preventive Rx List are free of charge and are not subject to the deductible.	
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). No coverage for non-formulary drugs. 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.*	0% coinsurance After deductible is met.	Not covered
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). No coverage for non-formulary drugs. 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.*	0% coinsurance After deductible is met.	Not Covered

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). No coverage for non-formulary drugs. 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.*	0% coinsurance After deductible is met.	Not Covered
Tier 4 - Typically Specialty (brand and generic) *Covers up to a 30-day supply (retail pharmacy). No coverage for non-formulary drugs. 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.*	0% coinsurance After deductible is met.	Not Covered

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.*	$15 copay Deductible does not apply	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 Deductible does not apply	Reimbursed Up to $30

Your summary of benefits

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.
- 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 provider's charge.
- 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 provider's 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 Benefits and Coverage".
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- Your copays, coinsurance and deductible count toward your out of pocket amount.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.

Questions: (833) 592-9956 or visit us at www.anthem.com

VA/LG/Anthem HSA 4JNB/01-01-2020

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 9956-592 (833) .

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 9956-592 (833) 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.

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 ła' 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.

Your summary of benefits

Anthem® BlueCross and BlueShield

Your Plan: Plan 7 PPO HSA (Embedded Deductible)

Your Network: KeyCare

This Schedule provides just a summary of the Covered Expenses, Limitations and Exclusions under the Plan. All benefits below are subject to the Plan's terms and conditions, including Deductibles, Coinsurance, In Network discounts and Allowable Charges, as set forth in the Plan Document to which this Schedule is attached. Please read this Schedule only in conjunction with the Plan Document.

Benefits payable by the Plan may change depending upon whether Covered Services are obtained from a Participating Provider. The list of Participating Providers may change from time to time. A list of Participating Providers is located at http://www.anthem.com. Therefore, it is important to verify that the Provider who is treating you is currently a Participating Provider.

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. See Prescription Drug Coverage section. Deductible is based on calendar year and will reset Jan. 1.*	$3,000 person / $6,000 family	$3,000 person / $6,000 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.*	$3,000 person / $6,000 family	$6,000 person / $12,000 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible. Preventive Chronic Conditions Per IRS Guidelines.*	No charge	40% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit to treat an injury or illness	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Specialist Care Visit	0% coinsurance after deductible is met	40% coinsurance after 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
Prenatal and Post-natal Care *In-Network preventive prenatal services are covered at 100%.*	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Other Practitioner Visits: Retail Health Clinic On-line Visit *Includes Mental Health and Substance Use Disorder* *Live Health Online is the preferred telehealth solution.* *(www.livehealthonline.com).* *Live Health On-line Dermatology- Specialty care* Chiropractic Services *Coverage for Rehabilitation and Habilitation is limited to 30 visits combined per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met
Other Services in an Office: Allergy Testing Chemo/Radiation Therapy Hemodialysis Prescription Drugs *For the drugs itself dispensed in the office through infusion/injection.*	0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after 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
Diagnostic Services		
Lab:		
Office	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Preferred Reference Lab	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	40% coinsurance after deductible is met
X-Ray:		
Office	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	40% coinsurance after 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
Emergency and Urgent Care		
Urgent Care Center Office Visit	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Emergency Room Facility Services	0% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	0% coinsurance after deductible is met	Covered as In-Network
Ambulance Transportation	0% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder		
Doctor Office Visit	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Facility visit:		
Facility Fees	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor Services	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Surgical Center	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor and Other Services:		

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Hospital	0% 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) *Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 100 days combined per admission. Limit is combined In-Network and Non-Network.*	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor and other services	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 90 visits per benefit period. Limit is combined In-Network and Non-Network. Limits are combined for home health care and private duty nursing.*	0% 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. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	0% 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. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Limit is combined for In-Network and Non-*	0% coinsurance after deductible is met	40% coinsurance after 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
Network. Limit is combined across professional visits and outpatient facilities.		
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. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Limit is combined across professional visits and outpatient facilities. 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.*	0% 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 combined per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Limit is combined across professional visits and outpatient facilities. 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.*	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Cardiac rehabilitation		
Office Visit *Coverage for cardiac rehabilitation is unlimited visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.*	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital *Coverage for cardiac rehabilitation is unlimited visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.*	0% 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 is limited to 100 days combined per admission. Limit is combined In-Network and Non-Network.*	0% coinsurance after deductible is met	40% coinsurance after 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
Hospice	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Durable Medical Equipment	0% coinsurance after deductible is met	40% coinsurance after 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.*	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Autism Spectrum Disorder (ASD) Therapeutic Care: unlimited physical, occupational and speech therapy	**0%** of the amount the health care professionals in our network have agreed to accept for their services	**40%** coinsurance after medical deductible is met
Applied Behavioral Analysis	**0%** of the amount the health care professionals in our network have agreed to accept for their services	**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	Combined with medical deductible.	Not applicable
Pharmacy Out of Pocket Coinsurance applies AFTER the deductible. Pharmacy member cost shares count towards the Medical out-of-pocket maximum.	Combined with Medical out of pocket.	Not applicable
Prescription Drug Coverage *National Direct Drug List* *This product has a 90-day Retail Pharmacy Network available. A 90-day supply is available at most retail pharmacies.*	Medications on the VPCBC Preventive Rx List are free of charge and are not subject to the deductible	
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). No coverage for non-formulary drugs. 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.*	0% coinsurance After deductible is met.	Not covered
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). No coverage for non-formulary drugs. 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.*	0% coinsurance After deductible is met.	Not Covered

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). No coverage for non-formulary drugs. 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.*	0% coinsurance After deductible is met.	Not Covered
Tier 4 - Typically Specialty (brand and generic) *Covers up to a 30-day supply (retail pharmacy). No coverage for non-formulary drugs. 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.*	0% coinsurance After deductible is met.	Not Covered

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.*	$15 copay Deductible does not apply	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 Deductible does not apply	Reimbursed Up to $30

Your summary of benefits

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.
- 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 provider's charge.
- 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 provider's 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 Benefits and Coverage".
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- Your copays, coinsurance and deductible count toward your out of pocket amount.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.

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VA/LG/Anthem HSA 4JNB/01-01-2020

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(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 9956-592 (833) .

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 9956-592 (833) 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.

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 ła' 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.

Your summary of benefits

Anthem® BlueCross and BlueShield

Your Plan: Plan 12 PPO HSA Embedded

Your Network: KeyCare

This Schedule provides just a summary of the Covered Expenses, Limitations and Exclusions under the Plan. All benefits below are subject to the Plan's terms and conditions, including Deductibles, Coinsurance, In Network discounts and Allowable Charges, as set forth in the Plan Document to which this Schedule is attached. Please read this Schedule only in conjunction with the Plan Document.

Benefits payable by the Plan may change depending upon whether Covered Services are obtained from a Participating Provider. The list of Participating Providers may change from time to time. A list of Participating Providers is located at www.anthem.com. Therefore, it is important to verify that the Provider who is treating you is currently a Participating Provider.

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. Deductible is based on a calendar year and it will reset Jan. 1.*	$5,000 person / $10,000 family	$5,000 person / $10,000 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.*	$6,750 person / $13,500 family	$7,750 person / $15,500 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible. Preventive Chronic Conditions Per IRS guidelines.*	No charge	40% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit to treat an injury or illness	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Specialist Care Visit	0% coinsurance after deductible is met	40% coinsurance after 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
Prenatal and Post-natal Care *In-Network preventive prenatal services are covered at 100%.*	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	0% coinsurance after deductible is met	40% coinsurance after deductible is met
On-line Visit *Includes Mental Health and Substance Use Disorder* *Live Health Online is the preferred telehealth solution.* *(www.livehealthonline.com).* *Live Health On-line Dermatology-specialty care*	0% coinsurance after deductible is met 0% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after 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. Limit is combined across professional visits and outpatient facilities.*	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Other Services in an Office:		
Allergy Testing	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Chemo/Radiation Therapy	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Hemodialysis	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Prescription Drugs *For the drugs itself dispensed in the office through infusion/injection.*	0% coinsurance after deductible is met	40% coinsurance after 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
Diagnostic Services		
Lab:		
Office	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Preferred Reference Lab	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	40% coinsurance after deductible is met
X-Ray:		
Office	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	40% coinsurance after 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
Emergency and Urgent Care		
Urgent Care Center Office Visit	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Emergency Room Facility Services	0% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	0% coinsurance after deductible is met	Covered as In-Network
Ambulance Transportation	0% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder		
Doctor Office Visit	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Facility visit:		
Facility Fees	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor Services	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Surgical Center	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor and Other Services:		

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Hospital	0% 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) *Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 100 days combined per benefit period. Limit is combined In-Network and Non-Network.*	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor and other services	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 90 visits per benefit period. Limit is combined In-Network and Non-Network. Limits are combined for home health care and private duty nursing.*	0% 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. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	0% 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. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Limit is combined for In-Network and Non-*	0% coinsurance after deductible is met	40% coinsurance after 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
Network. Limit is combined across professional visits and outpatient facilities.		
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. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Limit is combined across professional visits and outpatient facilities. 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.*	0% 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 combined per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Limit is combined across professional visits and outpatient facilities. 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.*	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Cardiac rehabilitation		
Office Visit *Coverage for cardiac rehabilitation is unlimited visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.*	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital *Coverage for cardiac rehabilitation is unlimited visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.*	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Skilled Nursing Care (in a facility)	0% coinsurance after deductible is met	40% coinsurance after 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
Coverage for Inpatient rehabilitation and skilled nursing services is limited to 100 days combined per admission. Limit is combined In-Network and Non-Network.		
Hospice	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Durable Medical Equipment	0% coinsurance after deductible is met	40% coinsurance after 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.*	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Autism Spectrum Disorder (ASD)		
Therapeutic Care: unlimited physical, occupational and speech therapy	**0%** of the amount the health care professionals in our network have agreed to accept for their services	**40%** coinsurance after medical deductible is met
Applied Behavioral Analysis	**0%** of the amount the health care professionals in our network have agreed to accept for their services	**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	Combined with the medical deductible.	Not applicable
Pharmacy Out of Pocket	Combined with medical out of pocket.	Not applicable
Prescription Drug Coverage *National Direct Drug List* *This product has a 90-day Retail Pharmacy Network available. A 90-day supply is available at most retail pharmacies.*	Medications on the VPCBC Preventive Rx List are free of charge and are not subject to the deductible	
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). No coverage for non-formulary drugs. 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.*	Retail (per 30-day supply): $10 copay/ prescription Mail Order: $10 copay/prescription	Not covered
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). No coverage for non-formulary drugs. 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.*	Retail (per 30-day supply):$35 copay/ prescription Mail Order: $70 copay/prescription	Not Covered

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). No coverage for non-formulary drugs. 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.*	Retail (per 30-day supply):$55 copay/ prescription Mail Order: $165 copay/prescription	Not Covered
Tier 4 - Typically Specialty (brand and generic) *Covers up to a 30-day supply (retail pharmacy). No coverage for non-formulary drugs. 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.*	20% to $200 per script maximum	Not Covered

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.*	$15 copay Deductible does not apply.	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 Deductible does not apply.	Reimbursed Up to $30

Your summary of benefits

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.
- 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 provider's charge.
- 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 provider's 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 Benefits and Coverage".
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- Your copays, coinsurance and deductible count toward your out of pocket amount.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.

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