Your summary of benefits

Anthem

Anthem® Blue Cross and Blue Shield

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	$0 person / $0 family	$500 person / $1,000 family
Out-of-Pocket Limit	$2,500 person / $5,000 family	$4,000 person / $8,000 family
When more than a single person is enrolled, the per person deductible does not apply and the family deductible must be met by any one person or collection of persons, but each is capped at his or her per person out-of-pocket maximum for covered services applied to the family deductible. Your copays, coinsurance and deductible count toward your out of pocket amount(s). In-network and out-of-network out-of-pocket maximum amounts are separate and do not accumulate toward each other.		
Preventive Care / Screening / Immunization	No charge	30% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	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
Virtual Care (Telemedicine / Telehealth Visits)		
Virtual Visits - Online visits with Doctors who also provide services in person		
Primary Care (PCP)	$25 copay per visit	30% coinsurance after medical deductible is met
Mental Health and Substance Abuse care	$25 copay per visit	30% coinsurance after medical deductible is met
Specialist	$50 copay per visit	30% coinsurance after medical deductible is met
Video Visits with Live Health Online via the Sydney mobile app or on Anthem.com		
Primary Care (PCP) and Mental Health and Substance Abuse	$5 copay per visit	
Specialist Care	$50 copay per visit	
Visits in an Office		
Primary Care (PCP)	$25 copay per visit	30% coinsurance after medical deductible is met
Specialist Care	$50 copay per visit	30% coinsurance after medical deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal) *Copay only applies to initial visit.*	$25 PCP/$50 Spec. copay per pregnancy for first 1 visit	30% coinsurance after medical deductible is met
Retail Health Clinic	$25 copay per visit	30% coinsurance after medical deductible is met
Manipulation Therapy *Coverage is limited to 30 visits per benefit period.*	$25 copay per visit	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
Other Services in an Office		
Allergy Testing	0% coinsurance	30% coinsurance after medical deductible is met
Chemo/Radiation Therapy	$25 PCP/$50 Spec. copay per visit‡	30% coinsurance after medical deductible is met
Dialysis/Hemodialysis	$25 PCP/$50 Spec.copay per visit‡	30% coinsurance after medical deductible is met
Prescription Drugs *Dispensed in the office*	$25 PCP/$50 Spec. copay per visit‡	30% coinsurance after medical deductible is met
Surgery	$25 PCP/$50 Spec. copay per surgery	30% coinsurance after medical deductible is met
Diagnostic Services		
Lab		
Office	$25 PCP/$50 Spec. copay per visit	30% coinsurance after medical deductible is met
Preferred Reference Lab	0% coinsurance	30% coinsurance after medical deductible is met
Outpatient Hospital	No charge	30% coinsurance after medical deductible is met
X-Ray		
Office	$25 PCP/$50 Spec.copay per visit	30% coinsurance after medical deductible is met
Outpatient Hospital	No charge	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
Advanced Diagnostic Imaging *for example: MRI, PET and 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
Emergency and Urgent Care		
Urgent Care	$25 PCP/ $50 Spec. 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	0% coinsurance	Covered as In-Network
Outpatient Mental Health and Substance Abuse		
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
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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Doctor and Other Services		
Hospital	0% coinsurance	30% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	$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
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 90 visits per benefit period. Limits are combined for all home health services.*	0% coinsurance	30% coinsurance after medical deductible is met
Rehabilitation services *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period.*		
Office	PT/OT $30 copay per visit. ST $25 PCP/$50 Spec. copay/visit	30% coinsurance after medical deductible is met
Outpatient Hospital	PT/OT $30 copay per visit. ST $50 Spec. copay/visit	30% coinsurance after medical deductible is met
Cardiac rehabilitation		
Office	$25 PCP/ $50 Spec. copay per visit	30% coinsurance after medical deductible is met
Outpatient Hospital	0% coinsurance	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
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 100 days combined per admission..*	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 is limited to 1 item after cancer treatment per benefit period. Limit is combined In-Network and Non- Network.*	0% coinsurance	30% coinsurance after medical deductible is met
Hearing Aids *One hearing aid per ear per 36 months, for adults and children, includes wearable and bone anchored hearing aids. $2,500 benefit maximum.*	0% coinsurance	30% coinsurance after medical deductible is met
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

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	$150 person / $300 family	Not covered
Pharmacy Out-of-Pocket Limit	$4,100 person / $8,200 family	Not covered
Prescription Drug Coverage *Cost shares for drugs included on the Essential Direct drug list appear below. Your plan uses the Advantage Network. You may receive up to a 90 day supply of medication at Rx Maintenance 90 pharmacies. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply. Drug cost share assistance programs may be available for certain specialty drugs.*		
Home Delivery Pharmacy 90 day supply (maximum cost shares noted below). Maintenance medications are available through CarelonRx Mail or at a participating Rx Maintenance 90 pharmacies.		
Preventive Drugs *No deductible, copayment or coinsurance for In-Network drugs included on the VPCBC Preventive Rx drug list, a designated list of drugs for the treatment of diabetes, asthma, depression, heart health, high blood pressure, high cholesterol, and osteoporosis. This list is free of charge and is not subject to the deductible.*		
Tier 1 Preventive - Typically Generic *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	0% coinsurance	Not covered (retail and home delivery)
Tier 2 Preventive - Typically Preferred Brand *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	0% coinsurance	Not covered (retail and home delivery)
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	$10 copay per prescription the Pharmacy deductible does not apply (retail and home delivery)	Not covered (retail and home delivery)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	Greater of $40 or 30% coinsurance up to $80 per prescription after Pharmacy deductible is met (retail) and Greater of $80 or 30% coinsurance up to $160 per prescription after Pharmacy deductible is met (home delivery)	Not covered (retail and home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Tier 3 - Typically Non-Preferred Brand *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	Greater of $60 or 40% coinsurance up to $120 per prescription after Pharmacy deductible is met (retail) and Greater of $120 or 40% coinsurance up to $240 per prescription after Pharmacy deductible is met (home delivery)	Not covered (retail and home delivery)
Tier 4 - Typically Specialty (brand and generic) *Per 30 day supply (specialty pharmacy).*	50% coinsurance up to $200 per prescription after Pharmacy deductible is met (retail) and (home delivery)	Not covered (retail and home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.		
Children's Vision (up to age 19) **Child Vision Deductible**	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	$15 copay	Reimbursed Up to $30
Adult Vision (age 19 and older) **Adult Vision Deductible**	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	$15 copay	Reimbursed Up to $30

Notes:

- If readmitted within 72 hours for the same diagnosis of the previous discharge, no additional facility copayment is required. If transferred between facilities, only one copayment will apply.
- The representations of benefits in this document are subject to Division of Insurance approval and are subject to change.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- ‡ Your cost share will be reduced when services are provided in a PCP's office.
- 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.
- 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.
- 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.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This policy has exclusions and limitations to benefits and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact your insurance agent or contact us. If there is a difference between this summary and the contract of coverage, the contract of coverage will prevail.

This benefit summary is not to be distributed without also providing access on limitations and exclusions that apply to our medical plans.

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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) 597-2358

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) 597-2358 .

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) 597-2358:

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) 597-2358。

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) 597-2358 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) 597-2358.

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) 597-2358.

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) 597-2358.

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) 597-2358 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) 597-2358로 문의하십시오.

Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'idiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí łą' bich'į' hadeesdzih ninízingo kojį' hodíilnih (833) 597-2358.

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) 597-2358.

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) 597-2358 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) 597-2358.

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) 597-2358.

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) 597-2358.

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) 597-2358.

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

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Your Plan: Plan 3 PPO

Your Network: KeyCare

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When more than a single person is enrolled, the per person deductible does not apply and the family deductible must be met by any one person or collection of persons, but each is capped at his or her per person out-of-pocket maximum for covered services applied to the family deductible. Your copays, coinsurance and deductible count toward your out of pocket amount(s). In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other.		
Preventive Care / Screening / Immunization	No charge	30% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	30% coinsurance after medical deductible is met
Virtual Care (Telemedicine / Telehealth Visits) **Virtual Visits - Online visits with Doctors who also provide services in person**		
Primary Care (PCP)	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
Mental Health and Substance Abuse care	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Specialist	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Video Visits with Live Health Online via the Sydney mobile app or on Anthem.com Primary Care (PCP) and Mental Health and Substance Abuse	20% coinsurance after medical deductible is met	
Specialist Care	20% coinsurance after medical deductible is met	
Visits in an Office		
Primary Care (PCP)	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Specialist Care	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Retail Health Clinic	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Manipulation Therapy *Coverage is limited to 30 visits per benefit period.*	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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Dialysis/Hemodialysis	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Prescription Drugs *Dispensed in the office*	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Surgery	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
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 and 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

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	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	20% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse		
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
Doctor and Other Services		
Hospital	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
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	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. Limits are combined for all home health services.*	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Rehabilitation services *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period.*		
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
Cardiac rehabilitation		
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
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 100 days combined per admission.*	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Hospice	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
Durable Medical Equipment	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment 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
Hearing Aids *One hearing aid per hearing impaired ear per 36 months, for adults and children, includes wearable and bone anchored hearing aids. $2,500 benefit maximum.*	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

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Not applicable	Not covered
Pharmacy Out-of-Pocket Limit	$4,600 person / $9,200 family	Not covered
Prescription Drug Coverage *Cost shares for drugs included on the Essential Direct drug list appear below. Your plan uses the Advantage Network. You may receive up to a 90 day supply of medication at Rx Maintenance 90 pharmacies. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply. Drug cost share assistance programs may be available for certain specialty drugs.*		
Home Delivery Pharmacy 90 day supply (maximum cost shares noted below). Maintenance medications are available through CarelonRx Mail or at a participating Rx Maintenance 90 pharmacies. You may get two 30 day supply fills of the same maintenance medication at a retail pharmacy. Prior to your 3rd fill, you must switch to home delivery		
Preventive Drugs *No deductible, copayment or coinsurance for In-Network drugs included on the VPCBC Preventive Rx drug list, a designated list of drugs for the treatment of diabetes, asthma, depression, heart health, high blood pressure, high cholesterol, and osteoporosis. The list is free of charge and are not subject to the deductible.*		
Tier 1 Preventive - Typically Generic *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	No charge	Not covered (retail and home delivery)
Tier 2 Preventive - Typically Preferred Brand *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	No charge	Not covered (retail and home delivery)
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	$10 copay per prescription, deductible does not apply (retail and home delivery)	Not covered (retail and home delivery)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	Greater of $40 or 30% coinsurance up to $80 per prescription, deductible does not apply (retail) and Greater of $80 or 30% coinsurance up to $160 per prescription, deductible does not apply (home delivery)	Not covered (retail and home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Tier 3 - Typically Non-Preferred Brand *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	Greater of $60 or 40% coinsurance up to $120 per prescription, deductible does not apply (retail) and Greater of $120 or 40% coinsurance up to $240 per prescription, deductible does not apply (home delivery)	Not covered (retail and home delivery)
Tier 4 - Typically Specialty (brand and generic) *Per 30 day supply (specialty pharmacy).*	50% coinsurance up to $200 per prescription, deductible does not apply (retail) and (home delivery)	Not covered (retail and home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.		
Children's Vision (up to age 19) **Child Vision Deductible**	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	$15 copay deductible does not apply	Reimbursed Up to $30
Adult Vision (age 19 and older) **Adult Vision Deductible**	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	$15 copay deductible does not apply	Reimbursed Up to $30

Notes:

- The representations of benefits in this document are subject to Division of Insurance approval and are subject to change.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- 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.
- 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.
- 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.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This policy has exclusions and limitations to benefits and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact your insurance agent or contact us. If there is a difference between this summary and the contract of coverage, the contract of coverage will prevail.

This benefit summary is not to be distributed without also providing access on limitations and exclusions that apply to our medical plans.

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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) 597-2358

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) 597-2358 .

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) 597-2358:

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) 597-2358。

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) 597-2358 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) 597-2358.

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) 597-2358.

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) 597-2358.

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) 597-2358 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) 597-2358로 문의하십시오.

Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'idiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih ninízingo kojį' hodíilnih (833) 597-2358.

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) 597-2358.

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) 597-2358 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) 597-2358.

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) 597-2358.

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) 597-2358.

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) 597-2358.

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®

Anthem® Blue Cross and Blue Shield

Your Plan: Plan 4 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 Deductible and Coinsurance. In Network Discounts and Allowable Charges, as set forth in the Plan Documents to which this Schedule is attached. Please read this Schedule only in conjunction with the Plan Documents.

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	$750 person / $1,500 family	$750 person / $1,500 family
Out-of-Pocket Limit	$3,250 person / $6,500 family	$4,500 person / $9,000 family
When more than a single person is enrolled, the per person deductible does not apply and the family deductible must be met by any one person or collection of persons, but each is capped at his or her per person out-of-pocket maximum for covered services applied to the family deductible. Your copays, coinsurance and deductible count toward your out of pocket amount(s). In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other.		
Preventive Care / Screening / Immunization	No charge	30% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	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
Virtual Care (Telemedicine / Telehealth Visits)		
Virtual Visits - Online visits with Doctors who also provide services in person		
Primary Care (PCP)	$20 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Mental Health and Substance Abuse care	$20 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Specialist	$40 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Video Visits with Live Health Online *via they Sydney mobile app or on Anthem.com*		
Primary Care (PCP) and Mental Health and Substance Abuse	$5 copay per visit medical deductible does not apply	
Specialist Care	$40 copay per visit medical deductible does not apply	
Visits in an Office		
Primary Care (PCP)	$20 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Specialist Care	$40 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal) *All office visit copayments count towards the same 1 visit limit.* *Copay only applies to initial visit.*	$20 PCP/ $40 Spec. copay per pregnancy for the first 1 visit medical deductible does not apply	30% coinsurance after medical deductible is met
Retail Health Clinic	$20 copay per visit medical deductible does not apply	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
Manipulation Therapy *Coverage is limited to 30 visits per benefit period.*	$40 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Other Services in an Office		
Allergy Testing	$20 PCP/$40 Spec. copay per visit medical deductible does not apply‡	30% coinsurance after medical deductible is met
Chemo/Radiation Therapy	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Dialysis/Hemodialysis	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Prescription Drugs *Dispensed in the office*	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Surgery	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Diagnostic Services **Lab**		
Office	$20 PCP/$40 Spec. copay per visit medical deductible does not apply	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 PCP/$40 Spec. copay per visit medical deductible does not apply	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
Outpatient Hospital	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and 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
Emergency and Urgent Care		
Urgent Care	$20 PCP/ $40 Spec. copay per visit medical deductible does not apply	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	20% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse		
Doctor Office Visit	$20 copay per visit medical deductible does not apply	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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
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
Doctor and Other Services		
Hospital	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	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.*	No charge	30% coinsurance after medical deductible is met
Rehabilitation services *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period.*		
Office	PT/OT $30 copay /visit ST $20 PCP/ $40 Spec copay/ visit medical deductible does not apply	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
Outpatient Hospital	PT/OT $30 copay/visit ST $20 PCP/$40 Spec. copay/visit medical deductible does not apply	30% coinsurance after medical deductible is met
Cardiac rehabilitation Office Outpatient Hospital	 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met	 30% coinsurance after medical deductible is met 30% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 100 days combined per admission.*	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
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 is limited to 1 item after cancer treatment 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
Hearing Aids *One hearing aid per hearing impaired ear per 36 months, for adults and children, includes wearable and bone anchored hearing aids. $2,500 benefit maximum.*	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
Applied Behavioral Analysis	No charge (deductible does not apply)	30% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	$150 person / $300 family	Not covered
Pharmacy Out-of-Pocket Limit	$3,350 person/ $6,700 family	Not covered

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Prescription Drug Coverage *Cost shares for drugs included on the Essential drug list appear below. Your plan uses the Advantage Network. You may receive up to a 90 day supply of medication at Rx Maintenance 90 pharmacies. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply. Drug cost share assistance programs may be available for certain specialty drugs.*		
Home Delivery Pharmacy 90 day supply (maximum cost shares noted below). Maintenance medications are available through CarelonRx Mail or at a participating Rx Maintenance 90 pharmacies. You may get two 30 day supply fills of the same maintenance medication at a retail pharmacy. Prior to your 3rd fill, you must switch to home delivery.		
Preventive Drugs *No deductible, copayment or coinsurance for In-Network drugs included on the VPCBC Preventive RX drug list, a designated list of drugs for the treatment of diabetes, asthma, depression, heart health, high blood pressure, high cholesterol, and osteoporosis. This list is free of charge and is not subject to the deductible.*		
Tier 1 Preventive - Typically Generic *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	No charge	Not covered (retail and home delivery)
Tier 2 Preventive - Typically Preferred Brand *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	No charge	Not covered (retail and home delivery)
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	$10 copay per prescription, Pharmacy deductible does not apply (retail and home delivery)	Not covered (retail and home delivery)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	Greater of $40 or 30% coinsurance up to $80 per prescription after Pharmacy deductible is met (retail) and Greater of $80 or 30% coinsurance up to $160 per prescription after Pharmacy deductible is met (home delivery)	Not covered (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	Greater of $60 or 40% coinsurance up to $120 per prescription after Pharmacy deductible is met (retail) and Greater of $120 or 40% coinsurance up to $240 per prescription after	Not covered (retail and home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
	Pharmacy deductible is met (home delivery)	
Tier 4 - Typically Specialty (brand and generic) *Per 30 day supply (specialty pharmacy).*	50% coinsurance up to $200 per prescription after Pharmacy deductible is met (retail) and (home delivery)	Not covered (retail and home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.		
Children's Vision (up to age 19) **Child Vision Deductible**	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	$15 copay deductible does not apply	Reimbursed Up to $30
Adult Vision (age 19 and older) **Adult Vision Deductible**	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	$15 copay deductible does not apply	Reimbursed Up to $30

Notes:

- The representations of benefits in this document are subject to Division of Insurance approval and are subject to change.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under “Outpatient Facility Services”.
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.

- ‡ Your cost share will be reduced when services are provided in a PCP's office.
- 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.
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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) 597-2358.

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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® Blue Cross and Blue Shield

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	$2,000 person / $4,000 family	$4,000 person / $8,000 family
Out-of-Pocket Limit	$4,000 person / $8,000 family	$6,000 person / $12,000 family
When more than a single person is enrolled, the per person deductible does not apply and the family deductible must be met by any one person or collection of persons, but each is capped at his or her per person out-of-pocket maximum for covered services applied to the family deductible. Your copays, coinsurance and deductible count toward your out of pocket amount(s). In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other.		
Preventive Care / Screening / Immunization	No charge	40% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Virtual Care (Telemedicine / Telehealth Visits)		
Virtual Visits - Online visits with Doctors who also provide services in person		
Primary Care (PCP)	$20 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Mental Health and Substance Abuse care	$20 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Specialist	$40 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Video Visits with Live Health online via the Sydney mobile app or on Anthem.com		
Primary Care (PCP) and Mental Health and Substance Abuse	$5 copay per visit medical deductible does not apply	
Specialist Care	$40 copay per visit medical deductible does not apply	
Visits in an Office		
Primary Care (PCP)	$20 PCP copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Specialist Care	$40 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal) *Copay only applies to initial visit.*	$20 PCP/$40 Spec. copay per pregnancy for the first 1 visit medical deductible does not apply	40% coinsurance after medical deductible is met
Retail Health Clinic	$20 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Manipulation Therapy *Coverage is limited to 30 visits per benefit period.*	$20 PCP/$40 Spec copay per visit medical deductible does not apply‡	40% coinsurance after medical deductible is met
Other Services in an Office		
Allergy Testing	$20 PCP/$40 Spec copay per visit medical deductible does not apply‡	40% coinsurance after medical deductible is met
Chemo/Radiation Therapy	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Dialysis/Hemodialysis	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prescription Drugs *Dispensed in the office*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Surgery	$20 PCP/$40 Spec copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Diagnostic Services **Lab**		
Office	$20 PCP/$40 Spec copay per visit medical deductible does not apply	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 Spec copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Emergency and Urgent Care		
Urgent Care	$20 PCP/ $40 Spec copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Emergency Room Facility Services	20% coinsurance after medical deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after medical deductible is met	Covered as In-Network
Ambulance	20% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse		
Doctor Office Visit	$20 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Facility Visit		
Facility Fees	No charge	40% coinsurance after medical deductible is met
Doctor Services	0% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Surgery		
Facility Fees		
Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Freestanding Surgical Center	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Doctor and Other Services		
Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Doctor and other services	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 90 visits per benefit period. Limits are combined for all home health services.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Rehabilitation services *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period.*		
Office	PT/OT $30 copay per visit medical deductible does not apply ST $20 PCP/$40 Spec. copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	PT/OT $30 copay per visit medical deductible does not apply ST$40 Spec copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Cardiac rehabilitation Office Outpatient Hospital	 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met	 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 100 days combined per admission.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Hospice	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Durable Medical Equipment	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment 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
Hearing Aids *One hearing aid per hearing impaired ear per 36 months, for adults and children, includes wearable and bone anchored hearing aids. $2,500 benefit maximum.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Autism Spectrum Disorder (ASD) Therapeutic Care: unlimited physical, occupational and speech therapy	Office Visit: **$**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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Applied Behavioral Analysis	20% coinsurance after deductible	40% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Not applicable	Not covered
Pharmacy Out-of-Pocket Limit	$2,600 person / $5,200 family	Not covered
Prescription Drug Coverage *Cost shares for drugs included on the Essential Direct drug list appear below. Your plan uses the Advantage Network. You may receive up to a 90 day supply of medication at Rx Maintenance 90 pharmacies. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply. Drug cost share assistance programs may be available for certain specialty drugs.*		
Home Delivery Pharmacy 90 day supply (maximum cost shares noted below). Maintenance medications are available through CarelonRx Mail or at a participating Rx Maintenance 90 pharmacies. You may get two 30 day supply fills of the same maintenance medication at a retail pharmacy. Prior to your 3rd fill, you must switch to home delivery.		
Preventive Drugs *No deductible, copayment or coinsurance for In-Network drugs included on the VPCBC Preventive Rx drug list, a designated list of drugs for the treatment of diabetes, asthma, depression, heart health, high blood pressure, high cholesterol, and osteoporosis. This list is free of charge and is not subject to the deductible.*		
Tier 1 Preventive - Typically Generic *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	No charge	Not covered (retail and home delivery)
Tier 2 Preventive - Typically Preferred Brand *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	No charge	Not covered (retail and home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	$10 copay per prescription, deductible does not apply (retail and home delivery)	Not covered (retail and home delivery)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	Greater of $40 or 30% coinsurance up to $80 per prescription, deductible does not apply (retail) and Greater of $80 or 30% coinsurance up to $160 per prescription, deductible does not apply (home delivery)	Not covered (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	Greater of $60 or 40% coinsurance up to $120 per prescription, deductible does not apply (retail) and Greater of $120 or 40% coinsurance up to $240 per prescription, deductible does not apply (home delivery)	Not covered (retail and home delivery)
Tier 4 - Typically Specialty (brand and generic) *Per 30 day supply (specialty pharmacy).*	50% coinsurance up to $200 per prescription, deductible does not apply (retail) and (home delivery)	Not covered (retail and home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.		
Children's Vision (up to age 19) **Child Vision Deductible**	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	$15 copay per visit deductible does not apply	Reimbursed Up to $30
Adult Vision (age 19 and older) **Adult Vision Deductible**	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	$15 copay per visit deductible does not apply	Reimbursed Up to $30

Notes:

- The representations of benefits in this document are subject to Division of Insurance approval and are subject to change.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- ‡ Your cost share will be reduced when services are provided in a PCP's office.
- 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

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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) 597-2358 ਤੇ ਕਾਲ ਕਰੋ।

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Your summary of benefits

Anthem®

Anthem® Blue Cross and Blue Shield

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 Deductible and Coinsurance. In Network Discounts and Allowable Charges, as set forth in the Plan Documents to which this Schedule is attached. Please read this Schedule only in conjunction with the Plan Documents.

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Overall Deductible	$1,700 person / $3,400 family	$1,700 person / $3,400 family
Out-of-Pocket Limit	$3,000 person / $6,000 family	$4,000 person / $8,000 family
The family deductible and out-of-pocket maximum are non-embedded, meaning the cost shares of all family members apply to one shared family deductible and one shared family out-of-pocket maximum. The per person deductible and per person out-of-pocket maximum only apply to individuals enrolled under single coverage. Your copays, coinsurance and deductible count toward your out of pocket amount(s). In-network and out-of-network deductibles are combined and accumulate toward each other; however, in-network and out-of-network out-of-pocket maximum amounts accumulate separately and do not accumulate toward each other.		
Preventive Care / Screening / Immunization	No charge	30% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	30% coinsurance after deductible is met
Virtual Care (Telemedicine / Telehealth Visits)		
Virtual Visits - Online visits with Doctors who also provide services in person		
Primary Care (PCP)	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Mental Health and Substance Abuse care	20% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Specialist	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Video Visits with Live Health Online via the Sydney mobile app or on Anthem.com		
Primary Care (PCP) and Mental Health and Substance Abuse	20% coinsurance after deductible is met	
Specialist Care	20% coinsurance after deductible is met	
Visits in an Office		
Primary Care (PCP)	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Specialist Care	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Retail Health Clinic	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 30 visits per benefit period.*	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
Dialysis/Hemodialysis	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Surgery	20% coinsurance after deductible is met	30% coinsurance after deductible is met

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 and 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
Emergency and Urgent Care		
Urgent Care	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	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse		
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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
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
Doctor and Other Services		
Hospital	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	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. Limits are combined for all home health services.*	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Rehabilitation services *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period.*		
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
Cardiac rehabilitation		
Office	20% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Skilled Nursing Care (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 deductible is met	30% coinsurance after deductible is met
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 is limited to 1 item after cancer treatment per benefit period. Limit is combined In-Network and Non-Network.*	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Hearing Aids *One hearing aid per hearing impaired ear per 36 months, for adults and children, includes wearable and bone anchored hearing aids. $2,500 benefit maximum.*	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Autism Spectrum Disorder (ASD) Therapeutic Care: unlimited physical, occupational and speech therapy Applied Behavioral Analysis	20% of the amount the health care professionals in our network have agreed to accept for their services 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 30% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with out of network medical deductible
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Not covered
Prescription Drug Coverage *Cost shares for drugs included on the Essential Direct drug list appear below. Your plan uses the Advantage Network. You may receive up to a 90 day supply of medication at Rx Maintenance 90 pharmacies. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply. Drug cost share assistance programs may be available for certain specialty drugs.*		
Home Delivery Pharmacy *Maintenance medications are available through CarelonRx Home Delivery Pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.*		
Preventive Drugs *No deductible, copayment or coinsurance for In-Network drugs included on the VPCBC Preventive Rx drug list, a designated list of drugs for the treatment of diabetes, asthma, depression, heart health, high blood pressure, high cholesterol, and osteoporosis. The list is free of charge and is not subject to the deductible.*		
Tier 1 Preventive - Typically Generic *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	No charge	Not covered (retail and home delivery)
Tier 2 Preventive - Typically Preferred Brand *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	No charge	Not covered (retail and home delivery)
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	20% coinsurance after deductible is met (retail and home delivery)	Not covered (retail and home delivery)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	20% coinsurance after deductible is met (retail and home delivery)	Not covered (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	20% coinsurance after deductible is met (retail and home delivery)	Not covered (retail and home delivery)
Tier 4 - Typically Specialty (brand and generic) *Per 30 day supply (specialty pharmacy).*	20% coinsurance after deductible is met (retail) and (home delivery)	Not covered (retail and home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.		
Children's Vision (up to age 19) **Child Vision Deductible**	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	$15 copay deductible does not apply	Reimbursed Up to $30
Adult Vision (age 19 and older) **Adult Vision Deductible**	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	$15 copay deductible does not apply	Reimbursed Up to $30

Notes:

- The representations of benefits in this document are subject to Division of Insurance approval and are subject to change.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- 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.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This policy has exclusions and limitations to benefits and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact your insurance agent or contact us. If there is a difference between this summary and the contract of coverage, the contract of coverage will prevail.

This benefit summary is not to be distributed without also providing access on limitations and exclusions that apply to our medical plans.

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Language Access Services:

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (833) 597-2358

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) 597-2358 .

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) 597-2358:

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) 597-2358。

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) 597-2358 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) 597-2358.

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) 597-2358.

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) 597-2358.

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) 597-2358 にお電話ください。

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Anthem® Blue Cross and Blue Shield

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Specialist	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Video Visits with Live Health Online via the Sydney mobile app or on Anthem.com		
Primary Care (PCP) and Mental Health and Substance Abuse	20% coinsurance after deductible is met	
Specialist Care	20% coinsurance after deductible is met	
Visits in an Office		
Primary Care (PCP)	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Specialist Care	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Retail Health Clinic	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 30 visits per benefit period.*	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
Dialysis/Hemodialysis	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Surgery	20% coinsurance after deductible is met	30% coinsurance after deductible is met

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 and 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
Emergency and Urgent Care		
Urgent Care	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	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse		
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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
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
Doctor and Other Services		
Hospital	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	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. Limits are combined for all home health services.*	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Rehabilitation services *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period.*		
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
Cardiac rehabilitation		
Office	20% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Skilled Nursing Care (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 deductible is met	30% coinsurance after deductible is met
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 is limited to 1 item after cancer treatment per benefit period. Limit is combined In-Network and Non-Network.*	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Hearing Aids *One hearing aid per hearing impaired ear per 36 months, for adults and children, includes wearable and bone anchored hearing aids. $2,500 benefit maximum.*	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Autism Spectrum Disorder (ASD) Therapeutic Care: unlimited physical, occupational and speech therapy Applied Behavioral Analysis	20% of the amount the health care professionals in our network have agreed to accept for their services 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 30% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with out of network medical deductible
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Not covered
Prescription Drug Coverage *Cost shares for drugs included on the Essential Direct drug list appear below. Your plan uses the Advantage Network. You may receive up to a 90 day supply of medication at Rx Maintenance 90 pharmacies. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply. Drug cost share assistance programs may be available for certain specialty drugs.*		
Home Delivery Pharmacy 90 day supply (maximum cost shares noted below). Maintenance medications are available through CarelonRx Mail or at a participating Rx Maintenance 90 pharmacies. You may get two 30 day supply fills of the same maintenance medication at a retail pharmacy. Prior to your 3rd fill, you must switch to home delivery.		
Preventive Drugs *No deductible, copayment or coinsurance for In-Network drugs included on the VPCBC Preventive Rx drug list, a designated list of drugs for the treatment of diabetes, asthma, depression, heart health, high blood pressure, high cholesterol, and osteoporosis. The list is free of charge and is not subject to the deductible.*		
Tier 1 Preventive - Typically Generic *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	No charge	Not covered (retail and home delivery)
Tier 2 Preventive - Typically Preferred Brand *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	No charge	Not covered (retail and home delivery)
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	20% coinsurance after deductible is met (retail and home delivery)	Not covered (retail and home delivery)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	20% coinsurance after deductible is met (retail and home delivery)	Not covered (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	20% coinsurance after deductible is met (retail and home delivery)	Not covered (retail and home delivery)
Tier 4 - Typically Specialty (brand and generic) *Per 30 day supply (specialty pharmacy).*	20% coinsurance after deductible is met (retail) and (home delivery)	Not covered (retail and home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.		
Children's Vision (up to age 19) **Child Vision Deductible**	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	$15 copay deductible does not apply	Reimbursed Up to $30
Adult Vision (age 19 and older) **Adult Vision Deductible**	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	$15 copay deductible does not apply	Reimbursed Up to $30

Notes:

- The representations of benefits in this document are subject to Division of Insurance approval and are subject to change.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- 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.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This policy has exclusions and limitations to benefits and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact your insurance agent or contact us. If there is a difference between this summary and the contract of coverage, the contract of coverage will prevail.

This benefit summary is not to be distributed without also providing access on limitations and exclusions that apply to our medical plans.

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Language Access Services:

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (833) 597-2358

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) 597-2358 .

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) 597-2358:

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) 597-2358。

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) 597-2358 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) 597-2358.

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) 597-2358.

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) 597-2358.

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) 597-2358 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) 597-2358로 문의하십시오.

Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'idiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí łą' bich'į' hadeesdzih ninízingo kojį' hodíilnih (833) 597-2358.

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) 597-2358.

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) 597-2358 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) 597-2358.

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) 597-2358.

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) 597-2358.

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) 597-2358.

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®

Anthem® Blue Cross and Blue Shield

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.

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	$3,400 person / $6,800 family	$3,400 person / $6,800 family
Out-of-Pocket Limit	$3,400 person / $6,800 family	$6,000 person / $12,000 family
The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per person 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 per person deductible or per person out-of-pocket maximum. Your copays, coinsurance and deductible count toward your out of pocket amount(s). In-network and out-of-network deductibles are combined and accumulate toward each other; however, in-network and out-of-network out-of-pocket maximum amounts accumulate separately and do not accumulate toward each other.		
Preventive Care / Screening / Immunization	No charge	40% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Virtual Care (Telemedicine / Telehealth Visits)		
Virtual Visits - Online visits with Doctors who also provide services in person		
Primary Care (PCP)	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Mental Health and Substance Abuse care	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Specialist	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Video Visits with Live Health Online via the Sydney mobile app or on Anthem.com		
Primary Care (PCP) and Mental Health and Substance Abuse	0% coinsurance after deductible is met	
Specialist Care	0% coinsurance after deductible is met	
Visits in an Office		
Primary Care (PCP)	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Specialist Care	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Retail Health Clinic	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 30 visits per benefit period.*	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
Dialysis/Hemodialysis	0% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prescription Drugs *Dispensed in the office*	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Surgery	0% coinsurance after deductible is met	40% coinsurance after deductible is met
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 and 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
Emergency and Urgent Care		
Urgent Care	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	0% coinsurance after deductible is met	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Mental Health and Substance Abuse		
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		
Hospital	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	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. Limits are combined for all home health services.*	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Rehabilitation services *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period.*		
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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Cardiac rehabilitation		
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
Skilled Nursing Care (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
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 is limited to 1 item after cancer treatment per benefit period. Limit is combined In-Network and Non-Network.*	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Hearing Aids *One hearing aid per hearing impaired ear per 36 months, for adults and children, includes wearable and bone anchored hearing aids. $2,500 benefit maximum.*	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 Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with out of network medical deductible
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Not covered
Prescription Drug Coverage *Cost shares for drugs included on the Essential Direct drug list appear below. Your plan uses the Advantage Network. You may receive up to a 90 day supply of medication at Rx Maintenance 90 pharmacies. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply. Drug cost share assistance programs may be available for certain specialty drugs.*		
Home Delivery Pharmacy 90 day supply (maximum cost shares noted below). Maintenance medications are available through CarelonRx Mail or at a participating Rx Maintenance 90 pharmacies. You may get two 30 day supply fills of the same maintenance medication at a retail pharmacy. Prior to your 3rd fill, you must switch to home delivery.		
Preventive Drugs *No deductible, copayment or coinsurance for In-Network drugs included on the VPCBC Preventive Rx drug list, a designated list of drugs for the treatment of diabetes, asthma, depression, heart health, high blood pressure, high cholesterol, and osteoporosis. The list is free of charge and is not subject to the deductible.*		
Tier 1 Preventive - Typically Generic *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	No charge	Not covered (retail and home delivery)
Tier 2 Preventive - Typically Preferred Brand *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	No charge	Not covered (retail and home delivery)
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	0% coinsurance after deductible is met (retail and home delivery)	Not covered (retail and home delivery)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	0% coinsurance after deductible is met (retail and home delivery)	Not covered (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	0% coinsurance after deductible is met (retail and home delivery)	Not covered (retail and home delivery)
Tier 4 - Typically Specialty (brand and generic) *Per 30 day supply (specialty pharmacy).*	0% coinsurance after deductible is met (retail) and (home delivery)	Not covered (retail and home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.		
Children's Vision (up to age 19) **Child Vision Deductible**	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	$15 copay deductible does not apply	Reimbursed Up to $30
Adult Vision (age 19 and older) **Adult Vision Deductible**	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	$15 copay deductible does not apply	Reimbursed Up to $30

Notes:

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- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- 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.
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- 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.
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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) 597-2358.

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®

Anthem® Blue Cross and Blue Shield

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	$3,400 person / $6,800 family	$3,400 person / $6,800 family
Out-of-Pocket Limit	$3,400 person / $6,800 family	$6,000 person / $12,000 family
The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per person 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 per person deductible or per person out-of-pocket maximum. Your copays, coinsurance and deductible count toward your out of pocket amount(s). In-network and out-of-network deductibles are combined and accumulate toward each other; however, in-network and out-of-network out-of-pocket maximum amounts accumulate separately and do not accumulate toward each other.		
Preventive Care / Screening / Immunization	No charge	40% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Virtual Care (Telemedicine / Telehealth Visits)		
Virtual Visits - Online visits with Doctors who also provide services in person		
Primary Care (PCP)	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Mental Health and Substance Abuse care	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Specialist	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Video Visits with Live Health Online via the Sydney mobile app or on Anthem.com		
Primary Care (PCP) and Mental Health and Substance Abuse	0% coinsurance after deductible is met	
Specialist Care	0% coinsurance after deductible is met	
Visits in an Office		
Primary Care (PCP)	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Specialist Care	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Retail Health Clinic	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 30 visits per benefit period.*	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
Dialysis/Hemodialysis	0% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prescription Drugs *Dispensed in the office*	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Surgery	0% coinsurance after deductible is met	40% coinsurance after deductible is met
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 and 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
Emergency and Urgent Care		
Urgent Care	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	0% coinsurance after deductible is met	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Mental Health and Substance Abuse		
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		
Hospital	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	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. Limits are combined for all home health services.*	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Rehabilitation services *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period.*		
Office	0% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Cardiac rehabilitation Office Outpatient Hospital	 0% coinsurance after deductible is met 0% coinsurance after deductible is met	 40% coinsurance after deductible is met 40% coinsurance after deductible is met
Skilled Nursing Care (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
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 is limited to 1 item after cancer treatment per benefit period. Limit is combined In-Network and Non-Network.*	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Hearing Aids *One hearing aid per hearing impaired ear per 36 months, for adults and children, includes wearable and bone anchored hearing aids. $2,500 benefit maximum.*	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Autism Spectrum Disorder (ASD) Therapeutic Care: unlimited physical, occupational and speech Therapy Applied Behavioral Analysis	0% of the amount the health care professionals in our network have agreed to accept for their services 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 40% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with out of network medical deductible
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Not covered
Prescription Drug Coverage *Cost shares for drugs included on the Essential Direct drug list appear below. Your plan uses the Advantage Network. You may receive up to a 90 day supply of medication at Rx Maintenance 90 pharmacies. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply. Drug cost share assistance programs may be available for certain specialty drugs.*		
Home Delivery Pharmacy 90 day supply (maximum cost shares noted below). Maintenance medications are available through CarelonRx Mail or at a participating Rx Maintenance 90 pharmacies. You may get two 30 day supply fills of the same maintenance medication at a retail pharmacy. Prior to your 3rd fill, you must switch to home delivery.		
Preventive Drugs *No deductible, copayment or coinsurance for In-Network drugs included on the VPCBC Preventive Rx drug list, a designated list of drugs for the treatment of diabetes, asthma, depression, heart health, high blood pressure, high cholesterol, and osteoporosis. The list is free of charge and is not subject to the deductible.*		
Tier 1 Preventive - Typically Generic *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	No charge	Not covered (retail and home delivery)
Tier 2 Preventive - Typically Preferred Brand *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	No charge	Not covered (retail and home delivery)
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Your summary of benefits

Anthem BlueCross BlueShield

And Its Affiliate HealthKeepers, Inc.

Anthem® Blue Cross and Blue Shield

Your Plan: Plan 12 PPO HSA

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 Deductible and Coinsurance. In Network Discounts and Allowable Charges, as set forth in the Plan Documents to which this Schedule is attached. Please read this Schedule only in conjunction with the Plan Documents.

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	$5,000 person / $10,000 family	$5,000 person / $10,000 family
Out-of-Pocket Limit	$6,750 person / $13,500 family	$7,750 person / $15,500 family
When more than a single person is enrolled, the per person deductible does not apply and the family deductible must be met by any one person or collection of persons, but each is capped at his or her per person out-of-pocket maximum for covered services applied to the family deductible. Your copays, coinsurance and deductible count toward your out of pocket amount(s). In-network and out-of-network deductibles amounts are combined and accumulate toward each other, However, In-network and out-of-network out-of-pocket maximum amounts are separate and do not accumulate toward each other.		
Preventive Care / Screening / Immunization	No charge	40% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	40% coinsurance after deductible is met
Virtual Care (Telemedicine / Telehealth Visits) **Virtual Visits - Online visits with Doctors who also provide services in person**		
Primary Care (PCP)	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Mental Health and Substance Abuse care	0% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Specialist	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Video Visits with Live Health Online via the Sydney mobile app or on Anthem.com		
Primary Care (PCP) and Mental Health and Substance Abuse	0% coinsurance after deductible is met	
Specialist Care	0% coinsurance after deductible is met	
Visits in an Office		
Primary Care (PCP)	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Specialist Care	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Retail Health Clinic	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 30 visits per benefit period.*	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
Dialysis/Hemodialysis	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Surgery	0% coinsurance after deductible is met	40% coinsurance after deductible is met

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 and 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
Emergency and Urgent Care		
Urgent Care	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	0% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse		
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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
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		
Hospital	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	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. Limits are combined for all home health services.*	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Rehabilitation services *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Limit is combined In-Network and Non-Network.*		
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
Cardiac rehabilitation Limit is combined In-Network and Non-Network.		
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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Skilled Nursing Care (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
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 is limited to 1 item after cancer treatment per benefit period. Limit is combined In-Network and Non-Network.*	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Hearing Aids *One hearing aid per hearing impaired ear per 36 months, for adults and children, includes wearable and bone anchored hearing aids. $2,500 benefit maximum.*	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Autism Spectrum Disorder (ASD) Therapeutic Care: unlimited physical, occupational and speech therapy Applied Behavioral Analysis	0% of the amount the health care professionals in our network have agreed to accept for their services 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 40% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with out of Network medical deductible
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Not covered
Prescription Drug Coverage *Cost shares for drugs included on the Essential Direct drug list appear below. Your plan uses the Advantage Network. You may receive up to a 90 day supply of medication at Rx Maintenance 90 pharmacies. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply. Drug cost share assistance programs may be available for certain specialty drugs.*		
Home Delivery Pharmacy 90 day supply (maximum cost shares noted below). Maintenance medications are available through CarelonRx Mail or at a participating Rx Maintenance 90 pharmacies. You may get two 30 day supply fills of the same maintenance medication at a retail pharmacy. Prior to your 3rd fill, you must switch to home delivery.		
Preventive Drugs *No deductible, copayment or coinsurance for In-Network drugs included on the VPCBC Preventive RX drug list, a designated list of drugs for the treatment of diabetes, asthma, depression, heart health, high blood pressure, high cholesterol, and osteoporosis. The list is free of charge and is not subject to the deductible.*		
Tier 1 Preventive - Typically Generic *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	No charge	Not covered (retail and home delivery)
Tier 2 Preventive - Typically Preferred Brand *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	No charge	Not covered (retail and home delivery)
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	$10 copay per prescription after deductible is met (retail and home delivery)	Not covered (retail and home delivery)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	$35 copay per prescription after deductible is met (retail) and $70 copay per prescription after deductible is met (home delivery)	Not covered (retail and home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Tier 3 - Typically Non-Preferred Brand *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	$55 copay per prescription after deductible is met (retail) and $165 copay per prescription after deductible is met (home delivery)	Not covered (retail and home delivery)
Tier 4 - Typically Specialty (brand and generic) *Per 30 day supply (specialty pharmacy).*	20% coinsurance up to $200 per prescription after deductible is met (retail) and (home delivery)	Not covered (retail and home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.		
Children's Vision (up to age 19) **Child Vision Deductible**	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	$15 copay deductible does not apply	Reimbursed Up to $30
Adult Vision (age 19 and older) **Adult Vision Deductible**	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	$15 copay deductible does not apply	Reimbursed Up to $30

Notes:

- The representations of benefits in this document are subject to Division of Insurance approval and are subject to change.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- 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.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This policy has exclusions and limitations to benefits and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact your insurance agent or contact us. If there is a difference between this summary and the contract of coverage, the contract of coverage will prevail.

This benefit summary is not to be distributed without also providing access on limitations and exclusions that apply to our medical plans.

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