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
Medical Chats and Virtual (Video) Visits for Primary Care from our Online Provider K Health, through its affiliated Provider groups	No charge	
Virtual Visits from Online Provider LiveHealth Online *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*		
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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Retail Health Clinic	$20 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
X-Ray		
Office	$20 PCP/$40 Spec. copay per visit medical deductible does not apply	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
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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Facility Visit		
Facility Fees	0% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Doctor Services	0% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Freestanding Surgical Center	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
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
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	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	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

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

Prescription Drug Coverage *Cost shares for drugs included on the National Direct drug list appear below. Your plan uses the Advantage Network. You may receive up to a 90 day supply of medication at Retail 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 medication 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 *Your Pharmacy cost share is waived for 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.*

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Tier 1 Preventive - Typically Generic *Per 30 day supply (retail pharmacy and Retail 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 Retail 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 Retail 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 Retail 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 Retail 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 Not covered (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 includesa 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. Thisamount 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.