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	$3,300 person / $6,600 family	$3,300 person / $6,600 family
Out-of-Pocket Limit	$3,300 person / $6,600 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
Medical Text Chats and Virtual Visits for Primary Care with K Health on the Sydney mobile app or on your Anthem.com account you will be transferred to the K Health app.	0% 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

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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
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
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	Not covered
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 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:

- 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.

Intentionally Left Blank

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.