

Your summary of benefits

Anthem Blue Cross and Blue Shield

Your Contract Code: 2T2W

Your Plan: Anthem Silver PPO 4000/20%/6850

Your Network: KeyCare

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

This benefit summary is not to be distributed without also providing access to the applicable Anthem enrollment brochure.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible <i>See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.</i>	\$4,000 person / \$8,000 family	\$8,000 person / \$16,000 family
Out-of-Pocket Limit <i>When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.</i>	\$6,850 person / \$13,700 family	\$13,700 person / \$27,400 family
Preventive care/screening/immunization <i>In-network preventive care is not subject to deductible, if your plan has a deductible.</i>	No charge	30% coinsurance after deductible is met
Doctor Home and Office Services Primary care visit to treat an injury or illness Enhanced Personal Healthcare provider	\$40 copay per visit deductible does not apply \$35 copay per visit deductible does not apply	30% coinsurance after deductible is met 30% coinsurance after deductible is met
Specialist care visit	\$60 copay per visit deductible does not apply	30% coinsurance after deductible is met

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Prenatal and Post-natal Care <i>In-Network preventative prenatal services are covered at 100%.</i>	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Other practitioner visits: Retail health clinic On-line Visit <i>Live Health On-Line is the preferred telehealth solutions (www.livehealthonline.com)</i> Chiropractor services <i>Coverage for In-Network Provider and Non-Network Provider combined is limited to 30 visits for Rehabilitation per benefit period. Coverage for In-Network Provider and Non-Network Provider combined is limited to 30 visits for Habilitation per benefit period.</i> Acupuncture	\$35 copay per visit deductible does not apply \$40 copay per visit deductible does not apply \$40 copay per visit deductible does not apply Not covered	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met Not covered
Other services in an office: Allergy testing Chemo/radiation therapy Hemodialysis Prescription drugs <i>For the drugs itself dispensed in the office thru infusion/injection</i>	\$35 copay per visit deductible does not apply 20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met

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Diagnostic Services Lab: <div>Office</div> <div>Freestanding Lab</div> <div>Outpatient Hospital</div>	<div>20% coinsurance after deductible is met</div> <div>20% coinsurance after deductible is met</div> <div>20% coinsurance after deductible is met</div>	<div>30% coinsurance after deductible is met</div> <div>30% coinsurance after deductible is met</div> <div>30% coinsurance after deductible is met</div>
X-ray: <div>Office</div> <div>Freestanding Radiology Center</div> <div>Outpatient Hospital</div>	<div>20% coinsurance after deductible is met</div> <div>20% coinsurance after deductible is met</div> <div>20% coinsurance after deductible is met</div>	<div>30% coinsurance after deductible is met</div> <div>30% coinsurance after deductible is met</div> <div>30% coinsurance after deductible is met</div>
Advanced diagnostic imaging (for example, MRI/PET/CAT scans): <div>Office</div> <div>Freestanding Radiology Center</div> <div>Outpatient Hospital</div>	<div>20% coinsurance after deductible is met</div> <div>20% coinsurance after deductible is met</div> <div>20% coinsurance after deductible is met</div>	<div>30% coinsurance after deductible is met</div> <div>30% coinsurance after deductible is met</div> <div>30% coinsurance after deductible is met</div>

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Emergency and Urgent Care Emergency room facility services <i>Copay waived if admitted.</i> Emergency room doctor and other services	\$350 copay per visit after deductible is met 20% coinsurance after deductible is met	\$350 copay per visit after deductible is met 20% coinsurance after deductible is met
Ambulance (air and ground)	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Urgent Care (office setting)	\$60 copay per visit deductible does not apply	30% coinsurance after deductible is met
Outpatient Mental/Behavioral Health and Substance Abuse Doctor office visit Facility visit: Facility fees	\$40 copay per visit deductible does not apply 20% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met
Outpatient Surgery Facility fees: Hospital Freestanding Surgical Center Doctor and other services	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met

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<p>Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)</p> <p>Facility fees (for example, room & board)</p> <p>Doctor and other services</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p>Recovery & Rehabilitation</p> <p>Home health care <i>Coverage for In-Network and Non-Network Provider combined is limited to 100 visits per benefit period. Visit limit does not apply to Home Infusion Therapy or Home Dialysis. Coverage for private duty nursing is limited to 16 hours per benefit period.</i></p>	<p>\$60 copay per visit deductible does not apply</p>	<p>30% coinsurance after deductible is met</p>
<p>Rehabilitation services (for example, physical/speech/occupational therapy):</p> <p>Office <i>Coverage for physical therapy and occupational therapy combined is limited to 30 visits per benefit period and Speech Therapy is limited to 30 visits per benefit period. Apply to In-Network Provider and Non-Network Provider combined. Visit limit does not apply when performed as part of Hospice or Home Health. Visit limits are combined both across outpatient and other professional visits, and in and out of network.</i></p> <p>Outpatient hospital <i>Coverage for physical therapy and occupational therapy combined is limited to 30 visits per benefit period and Speech Therapy is limited to 30 visits per benefit period. Apply to In-Network Provider and Non-Network Provider combined. Visit limit does not apply when performed as part of Hospice or Home Health. Visit limits are combined both across outpatient and other professional visits, and in and out of network.</i></p>	<p>\$40 copay per visit deductible does not apply</p> <p>20% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>

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<p>Habilitation services (for example, physical/speech/occupational therapy):</p> <p>Office <i>Coverage for physical therapy and occupational therapy combined is limited to 30 visits per benefit period and Speech Therapy is limited to 30 visits per benefit period. Apply to In-Network Provider and Non-Network Provider combined. Visit limit does not apply when performed as part of Hospice or Home Health. Visit limits are combined both across outpatient and other professional visits, and in and out of network.</i></p> <p>Outpatient hospital <i>Coverage for physical therapy and occupational therapy combined is limited to 30 visits per benefit period and Speech Therapy is limited to 30 visits per benefit period. Apply to In-Network Provider and Non-Network Provider combined. Visit limit does not apply when performed as part of Hospice or Home Health. Visit limits are combined both across outpatient and other professional visits, and in and out of network.</i></p>	<p>\$40 copay per visit deductible does not apply</p> <p>20% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p>Cardiac rehabilitation</p> <p>Office</p> <p>Outpatient hospital</p>	<p>\$60 copay per visit deductible does not apply</p> <p>20% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p>Skilled nursing care (in a facility) <i>Coverage for Inpatient rehabilitation and skilled nursing services combined In-Network Provider and Non-Network Provider combined is limited to 100 days per admission.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p>Hospice</p>	<p>20% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p>Durable Medical Equipment</p>	<p>20% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p>Prosthetics Devices <i>Coverage for wigs needed after cancer treatment In-Network and Non-Network Provider combined is limited to 1 unit per benefit period.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	\$250 person/\$500 family	\$250 person/\$500 family
Pharmacy Out of Pocket	\$6,850 person / \$13,700 family	\$13,700 person / \$27,400 family
Prescription Drug Coverage <i>Anthem Select Drug List</i> <i>This product has a 90 day Retail Pharmacy Network available.</i>		
Other Drug Coverage Tier 1 - Typically Generic <i>You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Covers up to a 90 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs. A 90 day supply is available at retail maintenance pharmacies with a copay for each 30 day supply. Coverage is also provided at retail for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time with a copay for each 30 day supply.</i>	\$15 copay per prescription deductible does not apply (retail only) and \$38 copay per prescription deductible does not apply (home delivery only)	30% coinsurance after pharmacy deductible is met (retail only)
Tier 2 - Typically Preferred Brand & Non-Preferred Generics <i>Covers up to a 90 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply. A 90 day supply is available at retail maintenance pharmacies with a copay for each 30 day supply. Coverage is also provided at retail for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time with a copay for each 30 day supply.</i>	\$45 copay per prescription after deductible is met (retail only) and \$135 copay per prescription after deductible is met (home delivery only)	30% coinsurance after pharmacy deductible is met (retail only)
Tier 3 - Typically Non-Preferred Brand and Generic drugs <i>Covers up to a 90 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply. A 90 day supply is available at retail maintenance pharmacies with a copay for each 30 day supply. Coverage is also provided at retail for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time with a copay for each 30 day supply.</i>	\$85 copay per prescription after deductible is met (retail only) and \$255 copay per prescription after deductible is met (home delivery only)	30% coinsurance after pharmacy deductible is met (retail only)

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Tier 4 - Typically Specialty (brand and generic) <i>Covers up to a 90 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program). No coverage for non-formulary drugs. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply. A 90 day supply is available at retail maintenance pharmacies with a copay for each 30 day supply. Coverage is also provided at retail for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time with a copay for each 30 day supply.</i>	30% coinsurance up to \$350 after deductible is met (retail and home delivery)	30% coinsurance after pharmacy deductible is met (retail only)

Your summary of benefits

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><i>This is a brief outline of your vision coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/ Disclosure form/ Certificate. If there is a difference between this summary and either Evidence of Coverage/ Disclosure form/ Certificate, the Evidence of Coverage/ Disclosure form/ Certificate will prevail. Only children's vision services count towards your out of pocket limit.</i></p>		
Children's Vision Essential Health Benefits Child Vision Deductible Vision exam <i>Coverage for In-Network Provider and Non-Network Provider combined is limited to 1 exam per benefit period. Limited reimbursement up to maximum allowable for out of network services</i>	Combined with medical deductible No charge	Combined with medical deductible No charge
Frames <i>Coverage for In-Network Provider and Non-Network Provider combined is limited to 1 unit per benefit period. Limited reimbursement up to maximum allowable for out of network services</i>	No charge	No charge
Lenses <i>Coverage for In-Network Provider and Non-Network Provider combined is limited to 1 unit per benefit period. Limited reimbursement up to maximum allowable for out of network services</i>	No charge	No charge
Elective contact lenses <i>Coverage for In-Network Provider and Non-Network Provider combined is limited to 1 unit per benefit period. Limited reimbursement up to maximum allowable for out of network services</i>	No charge	No charge
Non-Elective Contact Lenses <i>Coverage for In-Network Provider and Non-Network Provider combined is limited to 1 unit per benefit period. Limited reimbursement up to maximum allowable for out of network services</i>	No charge	No charge
Adult Vision Adult Vision Deductible Vision exam <i>Coverage for In-Network Provider and Non-Network Provider combined is limited to 1 exam per benefit period. Coverage for Non-Network Providers is limited to \$30 maximum benefit per visit.</i>	Combined with medical deductible \$20 copay per visit	Combined with medical deductible Amount above \$30 reimbursement

Your summary of benefits

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Frames	Not covered	Not covered
Lenses	Not covered	Not covered
Elective contact lenses	Not covered	Not covered
Non-Elective Contact Lenses	Not covered	Not covered

Your summary of benefits

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><i>This is a brief outline of your dental coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/ Disclosure form/ Certificate. If there is a difference between this summary and either Evidence of Coverage/ Disclosure form/ Certificate, the Evidence of Coverage/ Disclosure form/ Certificate will prevail.</i></p> <p><i>Only children's dental services count towards your out of pocket limit.</i></p>		
Children's Dental Essential Health Benefits Diagnostic and preventive <i>Coverage for In-Network Provider and Non-Network Provider combined is limited to 2 visits per 12 months.</i>	No charge	30% coinsurance
Basic services	40% coinsurance	50% coinsurance
Major services	50% coinsurance	50% coinsurance
Medical Necessary Orthodontia services	50% coinsurance	50% coinsurance
Cosmetic Orthodontia services	Not covered	Not covered
Deductible	Combined with medical deductible	Combined with medical deductible
Adult Dental		
Diagnostic and preventive	Not covered	Not covered
Basic services	Not covered	Not covered
Major services	Not covered	Not covered
Deductible	Not Applicable	Not Applicable
Annual maximum	\$0	\$0

Your summary of benefits

Your plan also includes the following health and wellness incentive rewards

Health assessment	Members are rewarded for completing online health assessment.	\$50 / year gift card
Tobacco free certification	By certifying online, members are rewarded for being tobacco free.	\$50 / year gift card
Adult wellness exam and annual flu shot	Members are rewarded for getting their annual adult wellness exam and annual flu shot. Members must complete both the wellness exam (\$50) and the flu shot (\$50) to receive \$100 in rewards. Activities can be completed in any order. Once the second of the two activities is complete, two \$50 rewards will be given.	\$100 / year in gift cards

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Notes:

- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- Your copays, coinsurance and deductible count toward your out of pocket amount
- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.
- Covered out-of-network Human Organ and Tissue Transplant services do not apply toward the out-of-pocket limit
- All medical services subject to a coinsurance are also subject to the annual medical deductible.
- 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, all services with calendar/plan year limits are combined both in and out of network.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.
- To view your prescription formulary list log on to www.anthem.com/health-insurance/customer-care/forms-library.
- 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 sbc.anthem.com to obtain a "Summary of Benefit Coverage".
- For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to sgplans.anthem.com/va/le/bcbs

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 (855)-330-1214.

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/ (عربي): نود أن نساعدك في فهم هذا المستند. يمكنك الحصول على المساعدة والمعلومات بلغتك مجاناً. للتحدث مع مترجم، اتصل على (855)-330-1214.

Armenian (հայերեն): Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հեռկալ հեռախոսահամարով՝ (855)-330-1214

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 (855)-330-1214

(فارسی): ما می‌توانیم به شما در فهمیدن این سند کمک کنیم. شما می‌توانید به کمک و اطلاعات به زبان خودتان به‌صورت رایگان. برای گفتن با مترجم، با (855)-330-1214 تماس بگیرید. **) Farsi (**

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 (855)-330-1214.

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 (855)-330-1214.

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 (855)-330-1214

(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、(855)-330-1214 にお電話ください。

Language Access Services:

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (855)-330-1214 로 문의하십시오.

(Navajo) (Diné): Díí naaltsoos biká'ígíí łahgo bina'ídiłkidgo ná bohónéedzá dóó bee ahóót'í' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bááh ilínigóó. Ata' halne'ígíí ła' bich'í' hadeesdzih nínízingo koji' hodiłnih (855)-330-1214.

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 (855)-330-1214.

(Punjabi) (ਗੁਰਮੁਖੀ): ਜੇਕਰ ਤੁਹਾਨੂੰ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੈ, ਤਾਂ ਤੁਹਾਨੂੰ ਆਪਣੇ ਆਪਣੇ ਭਾਸ਼ਣ ਵਿਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਆਪਣੇ ਭਾਸ਼ਣ ਵਿਚ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ (855)-330-1214 ਨੰਬਰ 'ਤੇ ਸੰਪਰਕ 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. (855)-330-1214.

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 (855)-330-1214.

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 (855)-330-1214.

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 (855)-330-1214.

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>.