Your summary of benefits

Anthem BlueCross BlueShield

UVA Physicians

Plan Year: 07/01/2020- 06/30/2021

Anthem Blue Cross and Blue Shield

Your Contract Code: 3KCF (custom)

Your Plan: Anthem KeyCare Plus 15/20%/3500 (custom)

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 *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$0 person / $0 family	$1,000 person / $2,000 family
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.*	$3,500 person / $7,000 family	$7,000 person / $14,000 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	30% coinsurance after deductible is met
Doctor Home and Office Services		
Primary care visit to treat an injury or illness	$15 copay per visit	30% coinsurance after deductible is met
Specialist care visit	$35 copay per visit	30% coinsurance after deductible is met
Prenatal and Post-natal Care	$200 copay per pregnancy	30% coinsurance after deductible is met

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Other practitioner visits:		
Retail health clinic	$15 copay per visit	30% coinsurance after deductible is met
On-line Medical Visit *Live Health Online is* the *preferred telehealth solutions (www.livehealthonline.com)*	$10 copay per visit	30% coinsurance after deductible is met
Chiropractic services *Coverage for In-Network Provider and Non-Network Provider combined is limited to 30 visits for Rehabilitation and Habilitative per benefit period.*	$15 copay per visit	30% coinsurance after deductible is met
Other services in an office:		
Allergy testing	$15 copay per visit	30% coinsurance after deductible is met
Chemo/radiation therapy	20% coinsurance	30% coinsurance after deductible is met
Dialysis/Hemodialysis	20% coinsurance	30% coinsurance after deductible is met
Prescription drugs *For the drugs itself dispensed in the office thru infusion/injection.*	20% coinsurance	30% coinsurance after deductible is met
Diagnostic Services		
Lab:		
Office	20% coinsurance	30% coinsurance after deductible is met
Preferred Reference Lab	Covered in full	30% coinsurance after deductible is met
Outpatient Hospital	$200 copay per visit	30% coinsurance after deductible is met

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X-ray:		
Office	20% coinsurance	30% coinsurance after deductible is met
Freestanding Radiology Center	$200 copay per visit	30% coinsurance after deductible is met
Outpatient Hospital	$200 copay per visit	30% coinsurance after deductible is met
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office	20% coinsurance	30% coinsurance after deductible is met
Freestanding Radiology Center	$200 copay per visit	30% coinsurance after deductible is met
Outpatient Hospital	$200 copay per visit	30% coinsurance after deductible is met
Emergency and Urgent Care		
Emergency room facility services	$250 copay per visit	Covered as In-Network
Emergency room doctor and other services	20% coinsurance	Covered as In-Network
Ambulance Transportation	20% coinsurance	Covered as In-Network
Urgent Care Center Office Visit	$35 copay per visit	30% coinsurance after deductible is met

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Outpatient Mental Health and Substance Use Disorder		
Doctor office visit and Online Visit	$15 copay per visit	30% coinsurance after deductible is met
Facility visit: Facility fees	$200 copay per visit	30% coinsurance after deductible is met
Doctor Services	$15 copay per visit	30% coinsurance after deductible is met
Outpatient Surgery		
Facility fees:		
Hospital	$200 copay per visit	30% coinsurance after deductible is met
Freestanding Surgical Center	$200 copay per visit	30% coinsurance after deductible is met
Doctor and other services		
Surgery	$35 copay per visit	30% coinsurance after deductible is met
Hospital Stay (all inpatient stays including maternity, mental and substance use disorder)		
Facility fees (for example, room & board) *Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 150 days combined per benefit period. Limit is combined In-Network and Non-Network.*	$250 copay per day up to 5 days per admission	30% coinsurance after deductible is met
Doctor and other services	$35 copay per visit	30% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Recovery & Rehabilitation		
Home health care *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.*	20% coinsurance	30% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy): Office *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Applies to In-Network Provider and Non-Network Provider combined. Visit limit does not apply when performed as part of Hospice, Home Health, Early Intervention or Autism services. Visit limits are combined both across outpatient and other professional visits, and in and out of network.*	$15 copay per visit	30% coinsurance after deductible is met
Outpatient hospital *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Applies to In-Network Provider and Non-Network Provider combined. Visit limit does not apply when performed as part of Hospice, Home Health, Early Intervention or Autism services. Visit limits are combined both across outpatient and other professional visits, and in and out of network.*	20% coinsurance	30% coinsurance after deductible is met

Habitation services (for example, physical/speech/occupational therapy): Office *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Applies to In-Network Provider and Non-Network Provider combined. Visit limit does not apply when performed as part of Hospice, Home Health, Early Intervention or Autism services. Visit limits are combined both across outpatient and other professional visits, and in and out of network.*	$15 copay per visit	30% coinsurance after deductible is met
Outpatient hospital *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Applies to In-Network Provider and Non-Network Provider combined. Visit limit does not apply when performed as part of Hospice, Home Health, Early Intervention or Autism services. Visit limits are combined both across outpatient and other professional visits, and in and out of network.*	20% coinsurance	30% coinsurance after deductible is met
Cardiac rehabilitation Office Visit *Coverage for cardiac rehabilitation is limited to 36 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.*	$35 copay per visit	30% coinsurance after deductible is met
Outpatient hospital *Coverage for cardiac rehabilitation is limited to 36 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.*	20% coinsurance	30% coinsurance after deductible is met
Skilled nursing care (in a facility) *Coverage for Inpatient rehabilitation and skilled nursing services combined In-Network Provider and Non-Network Provider combined is limited to 150 days per admission.*	$250 copay per day up to 5 days per admission	30% coinsurance after deductible is met
Hospice	20% coinsurance	30% coinsurance after deductible is met
Durable Medical Equipment	20% coinsurance	30% coinsurance after deductible is met

Prosthetic Devices *Coverage for wigs needed after cancer treatment In-Network and Non-Network Provider combined is limited to 1 unit per benefit period.*	20% coinsurance	30% coinsurance after deductible is met

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Not Applicable	Not Applicable
Pharmacy Out of Pocket	Combined with medical out of pocket	Combined with medical out of pocket
Prescription Drug Coverage *Anthem Essential Drug List* *This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.*		
Tier 1 - Typically Generic *You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Covers up to a 30 day supply (retail pharmacy). Covers up to 90 day supply (retail maintenance pharmacy) Covers up to a 90 day supply (home delivery program.) No coverage for non-formulary drugs. Note: 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.*	$15 copay per prescription (retail only). $38 copay per prescription (home delivery only).	30% coinsurance (retail and home delivery).
Tier 2 - Typically Preferred Brand & Non-Preferred Generics *You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Covers up to a 30 day supply (retail pharmacy). Covers up to 90 day supply (retail maintenance pharmacy) Covers up to a 90 day supply (home delivery program.) No coverage for non-formulary drugs. Note: 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.*	$50 copay per prescription (retail only). $125 copay per prescription (home delivery only).	30% coinsurance (retail and home delivery).
Tier 3 - Typically Non-Preferred Brand *You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Covers up to a 30 day supply (retail pharmacy). Covers up to 90 day supply (retail maintenance pharmacy) Covers up to a 90 day supply (home delivery program.) No coverage for non-formulary drugs. Note: 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.*	$85 copay per prescription (retail only). $213 copay per prescription (home delivery only).	30% coinsurance (retail and home delivery).

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Tier 4 - Typically Preferred Specialty (brand and generic) *You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Covers up to a 30 day supply (retail pharmacy). Covers up to 30 day supply (home delivery program.) Note: 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. No coverage for non-formulary drugs.*	20% coinsurance up to $250 (retail and home delivery).	30% coinsurance (retail and home delivery).

Your summary of benefits

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail.		
Child Vision exam *Coverage for In-Network Providers is limited to 1 exam per benefit period.*	No charge	$30 reimbursement
Adult Vision exam *Coverage for In-Network Providers is limited to 1 exam per benefit period.*	$15 copay per visit	$30 reimbursement

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Notes:

- 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.
- Your coinsurance, copays and deductible count toward your out of pocket amount.
- For additional information on this plan, please visit sbc.anthem.com to obtain a "Summary of Benefit Coverage".
- 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, all services with calendar/plan year limits are combined both in and out of network.
- 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 providers 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.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.

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 (844) 682-6553.

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 (844) 682-6553.

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՝ (844) 682-6553:

Chinese(□□)：□□□□□□□□□□□□，□□□□□□□□□□□□□□□□□。□□□□□□□，□□□ (844) 682-6553。

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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 (844) 682-6553.

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 (844) 682-6553.

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 (844) 682-6553.

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Navajo (Diné): Díí naaltsoos bikáʼígíí łahgo bínaʼídíłkidgo ná bohónéedzą́ dóó bee ahóótʼiʼ tʼáá ni nizaad kʼehjí bee nił hodoonih tʼáadoo bą́ą́h ílínígóó. Ataʼ halneʼígíí łaʼ bichʼį́ hadeesdzih nínízingo kojį́ʼ hodíílnih (844) 682-6553.

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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: (844) 682-6553.

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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 (844) 682-6553.

It's important we treat you fairly
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