UVA Physicians

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.

<table>
<thead>
<tr>
<th>Covered Medical Benefits</th>
<th>Cost if you use an In-Network Provider</th>
<th>Cost if you use a Non-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall Deductible</strong></td>
<td>$0 person / $0 family</td>
<td>$1,000 person / $2,000 family</td>
</tr>
<tr>
<td><em>See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Out-of-Pocket Limit</strong></td>
<td>$3,500 person / $7,000 family</td>
<td>$7,000 person / $14,000 family</td>
</tr>
<tr>
<td><em>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.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preventive care/screening/immunization</strong></td>
<td>No charge</td>
<td>30% coinsurance after deductible is met</td>
</tr>
<tr>
<td><em>In-network preventive care is not subject to deductible, if your plan has a deductible.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Doctor Home and Office Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Primary care visit to treat an injury or illness</strong></td>
<td>$15 copay per visit</td>
<td>30% coinsurance after deductible is met</td>
</tr>
<tr>
<td><strong>Specialist care visit</strong></td>
<td>$35 copay per visit</td>
<td>30% coinsurance after deductible is met</td>
</tr>
<tr>
<td><strong>Prenatal and Post-natal Care</strong></td>
<td>$200 copay per pregnancy</td>
<td>30% coinsurance after deductible is met</td>
</tr>
<tr>
<td>Covered Medical Benefits</td>
<td>Cost if you use an In-Network Provider</td>
<td>Cost if you use a Non-Network Provider</td>
</tr>
<tr>
<td>--------------------------</td>
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</tr>
<tr>
<td><strong>Other practitioner visits:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retail health clinic</td>
<td>$15 copay per visit</td>
<td>30% coinsurance after deductible is met</td>
</tr>
<tr>
<td>On-line Medical Visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Live Health Online is the preferred telehealth solutions</em> (<a href="http://www.livehealthonline.com">www.livehealthonline.com</a>)</td>
<td>$15 copay per visit</td>
<td>30% coinsurance after deductible is met</td>
</tr>
<tr>
<td>Chiropractic services</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Coverage for In-Network Provider and Non-Network Provider combined is limited to 30 visits for Rehabilitation and Habilitative per benefit period.</em></td>
<td>$15 copay per visit</td>
<td>30% coinsurance after deductible is met</td>
</tr>
<tr>
<td><strong>Other services in an office:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy testing</td>
<td>$15 copay per visit</td>
<td>30% coinsurance after deductible is met</td>
</tr>
<tr>
<td>Chemo/radiation therapy</td>
<td>20% coinsurance</td>
<td>30% coinsurance after deductible is met</td>
</tr>
<tr>
<td>Dialysis/Hemodialysis</td>
<td>20% coinsurance</td>
<td>30% coinsurance after deductible is met</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>20% coinsurance</td>
<td>30% coinsurance after deductible is met</td>
</tr>
<tr>
<td><em>For the drugs itself dispensed in the office thru infusion/injection.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostic Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lab:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office</td>
<td>20% coinsurance</td>
<td>30% coinsurance after deductible is met</td>
</tr>
<tr>
<td>Preferred Reference Lab</td>
<td>Covered in full</td>
<td>30% coinsurance after deductible is met</td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>$200 copay per visit</td>
<td>30% coinsurance after deductible is met</td>
</tr>
</tbody>
</table>
## Covered Medical Benefits

<table>
<thead>
<tr>
<th>Covered Medical Benefits</th>
<th>Cost if you use an In-Network Provider</th>
<th>Cost if you use a Non-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>X-ray:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office</td>
<td>20% coinsurance</td>
<td>30% coinsurance after deductible is met</td>
</tr>
<tr>
<td>Freestanding Radiology Center</td>
<td>$200 copay per visit</td>
<td>30% coinsurance after deductible is met</td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>$200 copay per visit</td>
<td>30% coinsurance after deductible is met</td>
</tr>
<tr>
<td>Advanced diagnostic imaging (for example, MRI/PET/CAT scans):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office</td>
<td>20% coinsurance</td>
<td>30% coinsurance after deductible is met</td>
</tr>
<tr>
<td>Freestanding Radiology Center</td>
<td>$200 copay per visit</td>
<td>30% coinsurance after deductible is met</td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>$200 copay per visit</td>
<td>30% coinsurance after deductible is met</td>
</tr>
<tr>
<td>Emergency and Urgent Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency room facility services</td>
<td>$250 copay per visit</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td>Emergency room doctor and other services</td>
<td>20% coinsurance</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td>Ambulance Transportation</td>
<td>20% coinsurance</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td>Urgent Care Center Office Visit</td>
<td>$35 copay per visit</td>
<td>30% coinsurance after deductible is met</td>
</tr>
<tr>
<td>Covered Medical Benefits</td>
<td>Cost if you use an In-Network Provider</td>
<td>Cost if you use a Non-Network Provider</td>
</tr>
<tr>
<td>--------------------------------------------------------------</td>
<td>----------------------------------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td><strong>Outpatient Mental Health and Substance Use Disorder</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor office visit and Online Visit</td>
<td>$15 copay per visit</td>
<td>30% coinsurance after deductible is met</td>
</tr>
<tr>
<td>Facility visit:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility fees</td>
<td>$200 copay per visit</td>
<td>30% coinsurance after deductible is met</td>
</tr>
<tr>
<td>Doctor Services</td>
<td>$15 copay per visit</td>
<td>30% coinsurance after deductible is met</td>
</tr>
<tr>
<td><strong>Outpatient Surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility fees:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>$200 copay per visit</td>
<td>30% coinsurance after deductible is met</td>
</tr>
<tr>
<td>Freestanding Surgical Center</td>
<td>$200 copay per visit</td>
<td>30% coinsurance after deductible is met</td>
</tr>
<tr>
<td>Doctor and other services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td>$35 copay per visit</td>
<td>30% coinsurance after deductible is met</td>
</tr>
<tr>
<td><strong>Hospital Stay (all inpatient stays including maternity, mental and substance use disorder)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility fees (for example, room &amp; board)</td>
<td>$250 copay per day up to 5 days per admission</td>
<td>30% coinsurance after deductible is met</td>
</tr>
<tr>
<td>Doctor and other services</td>
<td>$35 copay per visit</td>
<td>30% coinsurance after deductible is met</td>
</tr>
<tr>
<td>Covered Medical Benefits</td>
<td>Cost if you use an In-Network Provider</td>
<td>Cost if you use a Non-Network Provider</td>
</tr>
<tr>
<td>--------------------------</td>
<td>---------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Recovery &amp; Rehabilitation</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Home health care</strong></td>
<td>20% coinsurance</td>
<td>30% coinsurance after deductible is met</td>
</tr>
<tr>
<td><em>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.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Rehabilitation services (for example, physical/speech/occupational therapy):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office</td>
<td><strong>$15 copay per visit</strong></td>
<td>30% coinsurance after deductible is met</td>
</tr>
<tr>
<td><em>Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period.</em></td>
<td><strong>20% coinsurance</strong></td>
<td></td>
</tr>
<tr>
<td><em>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.</em></td>
<td><strong>20% coinsurance</strong></td>
<td></td>
</tr>
<tr>
<td>Outpatient hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>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.</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Habilitation 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.

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.

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.

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.

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.

Hospice

Durable Medical Equipment
<table>
<thead>
<tr>
<th>Prosthetic Devices</th>
<th>In-Network and Non-Network Provider combined is limited to 1 unit per benefit period.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>30% coinsurance after deductible is met</td>
</tr>
</tbody>
</table>
## Covered Prescription Drug Benefits

<table>
<thead>
<tr>
<th>Covered Prescription Drug Benefits</th>
<th>Cost if you use an In-Network Provider</th>
<th>Cost if you use a Non-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy Deductible</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Pharmacy Out of Pocket</td>
<td>Combined with medical out of pocket</td>
<td>Combined with medical out of pocket</td>
</tr>
</tbody>
</table>

### 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.

- **Cost:**
  - $15 copay per prescription (retail only).
  - $38 copay per prescription (home delivery only).
- **Coinsurance:**
  - 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.

- **Cost:**
  - $50 copay per prescription (retail only).
  - $125 copay per prescription (home delivery only).
- **Coinsurance:**
  - 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.

- **Cost:**
  - $85 copay per prescription (retail only).
  - $213 copay per prescription (home delivery only).
- **Coinsurance:**
  - 30% coinsurance (retail and home delivery).
<table>
<thead>
<tr>
<th>Covered Prescription Drug Benefits</th>
<th>Cost if you use an In-Network Provider</th>
<th>Cost if you use a Non-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tier 4 - Typically Preferred Specialty (brand and generic)</strong></td>
<td>20% coinsurance up to $250 (retail and home delivery).</td>
<td>30% coinsurance (retail and home delivery).</td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.
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.

<table>
<thead>
<tr>
<th>Covered Vision Benefits</th>
<th>Cost if you use an In-Network Provider</th>
<th>Cost if you use a Non-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Vision exam</td>
<td>No charge</td>
<td>$30 reimbursement</td>
</tr>
<tr>
<td><em>Coverage for In-Network Providers is limited to 1 exam per benefit period.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult Vision exam</td>
<td>$15 copay per visit</td>
<td>$30 reimbursement</td>
</tr>
<tr>
<td><em>Coverage for In-Network Providers is limited to 1 exam per benefit period.</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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 المنشور، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مكافأة. للتحدث إلى مترجم، اتصل على 5553-682-(844).

Armenian (հայերեն): Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար կոտորածիր (844) 682-6553:

Chinese(中文)：如果您对这份文件有任何疑问，您有权免费获得帮助和信息。如果您需要一位口译，可以拨打(844) 682-6553。

Chinese(简体中文)：如对本文件有任何疑问，您有权免费获得帮助和信息。如需与口译员通话，可拨打(844) 682-6553。

Chinese(繁體中文)：如對本文件有任何問題，您有權免費獲得幫助和資訊。如需與翻譯員通話，請拨打(844) 682-6553。

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 nenpò 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.

Japanese (日本語): この文書については何にか不明な点があれば、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、(844) 682-6553 にお電話ください。

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하의 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (844) 682-6553 로 문의하십시오.

Navajo (Dine): Díí naaltsoos biká’ígíí lahgo bíná’idíldígo ná bohónéédzá dóó bee ahóóít’í t’áá ni nízaad ké’jí bee níl hodooní ni jáadóó bi’áá’ilíngóó. Atá hánte’éegi lá’i bích’í’ hadedészhí níínízíngó ko’jí ho’dílínííhíhíhí (844) 682-6553.
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.