Your summary of benefits

Anthem® Blue Cross and Blue Shield | UVA Physicians

Your Contract Code: 3KCF (Custom) | 07/01/2023 – 06/30/2024

Your Plan: Anthem KeyCare Plus 15/20%/3500 Rx $15/$50/$85/20% w/Enhanced Preventive RX @ 100%

Your Network: KeyCare

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$0 person / $0 family	$1,000 person / $2,000 family
Out-of-Pocket Limit	$3,500 person / $7,000 family	$7,000 person / $14,000 family
The family out-of-pocket maximum is embedded, meaning the cost shares of one family member will be applied to the per person out-of-pocket maximum; in addition, amounts for all covered family members apply to the family out-of-pocket maximum. No one member will pay more than the 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 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
<u>Virtual Care (Telemedicine / Telehealth Visits)</u> **Virtual Visits - Online visits with Doctors who also provide services in person**		
Primary Care (PCP)	$15 copay per visit	30% coinsurance after medical deductible is met
Mental Health and Substance Abuse care	$15 copay per visit	30% coinsurance after medical deductible is met
Specialist	$35 copay per visit	30% coinsurance after medical deductible is met

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
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)	$15.00 copay per visit	
Mental Health and Substance Abuse	$0 copay per visit	
Specialist Care	$35 copay per visit	
Visits in an Office		
Primary Care (PCP)	$15 copay per visit	30% coinsurance after medical deductible is met
Specialist Care	$35 copay per visit	30% coinsurance after medical deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	$200 copay per pregnancy	30% coinsurance after medical deductible is met
Retail Health Clinic	$15 copay per visit	30% coinsurance after medical deductible is met
Manipulation Therapy *Coverage is limited to 30 visits per benefit period.*	$15 copay per visit	30% coinsurance after medical deductible is met
Other Services in an Office		
Allergy Testing	$15 copay per visit	30% coinsurance after medical deductible is met
Chemo/Radiation Therapy	20% coinsurance	30% coinsurance after medical deductible is met
Dialysis/Hemodialysis	20% coinsurance	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
Prescription Drugs *Dispensed in the office*	20% coinsurance	30% coinsurance after medical deductible is met
Surgery	$35 copay per surgery	30% coinsurance after medical deductible is met
Diagnostic Services		
Lab		
Office	No charge	30% coinsurance after medical deductible is met
Preferred Reference Lab	No charge	30% coinsurance after medical deductible is met
Outpatient Hospital	$200 copay per visit	30% coinsurance after medical deductible is met
X-Ray		
Office	20% coinsurance	30% coinsurance after medical deductible is met
Outpatient Hospital	$200 copay per visit	30% coinsurance after medical deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	20% coinsurance	30% coinsurance after medical deductible is met
Outpatient Hospital	$200 copay per service	30% coinsurance after medical deductible is met
Emergency and Urgent Care		
Urgent Care	$35 copay per visit	30% coinsurance after medical deductible is met
Emergency Room Facility Services	$250 copay per visit	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Copay waived if admitted.		
Emergency Room Doctor and Other Services	20% coinsurance	Covered as In-Network
Ambulance	20% coinsurance	Covered as In-Network
Outpatient Mental Health and Substance Abuse		
Doctor Office Visit	$15 copay per visit	30% coinsurance after medical deductible is met
Facility Visit		
Facility Fees	$200 copay per visit	30% coinsurance after medical deductible is met
Doctor Services	$15 copay per visit	30% coinsurance after medical deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	$200 copay per visit	30% coinsurance after medical deductible is met
Freestanding Surgical Center	$200 copay per visit	30% coinsurance after medical deductible is met
Doctor and Other Services		
Hospital	$35 copay per visit	30% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	$250 copay per day to a maximum of $1,250 per admission	30% coinsurance after medical deductible is met
Doctor and other services	$35 copay per visit	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
<u>**Recovery & Rehabilitation**</u> **Home Health Care** *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	20% coinsurance	30% coinsurance after medical 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	$15 copay per visit	30% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance	30% coinsurance after medical deductible is met
Cardiac rehabilitation *Coverage is limited to 36 visits per benefit period.*		
Office	$35 copay per visit	30% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance	30% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.*	$250 copay per day to a maximum of $1,250 per admission	30% coinsurance after medical deductible is met
Inpatient Hospice	20% coinsurance	30% coinsurance after medical deductible is met
Durable Medical Equipment	20% coinsurance	30% coinsurance after medical deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	20% coinsurance	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	Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Prescription Drug Coverage *Cost shares for drugs included on the Essential drug list appear below. Drugs not included on the Essential drug list will not be covered. Your plan uses the Base (National) Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies. Enhanced Preventive Rx Drug List covered at 100% before deductible, out-of-network covered at 30% coinsurance deductible does not apply.*		
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. Home Delivery is an optional service on this plan.*		
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$15 copay per prescription, deductible does not apply (retail) and $38 copay per prescription, deductible does not apply (home delivery)	30% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$50 copay per prescription, deductible does not apply (retail) and $125 copay per prescription, deductible does not apply (home delivery)	30% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$85 copay per prescription, deductible does not apply (retail) and $213 copay per prescription, deductible does not apply (home delivery)	30% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) *Per 30 day supply (specialty pharmacy).*	20% coinsurance up to $250 per prescription, deductible does not apply (retail and home delivery)	30% coinsurance, deductible does not apply (retail) and Not covered (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.*	No charge	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	Reimbursed Up to $30

Notes:

- If readmitted within 72 hours for the same diagnosis of the previous discharge, no additional facility copayment is required. If transferred between facilities, only one copayment will apply.
- 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.

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. Visit https://www.anthemplancomparison.com/va to access this information.

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(TTY/TDD: 711)

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