Your summary of benefits

Anthem BlueCross BlueShield

Anthem Blue Cross and Blue Shield (City of Hampton)

Your Contract Code: 398A

Your Plan: Anthem KeyCare Plus 15/20%/3500

Your Network: KeyCare PPO

This summary of benefits is a brief outline of coverage, designed to help you with your decision making process.

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	$400 person / $800 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.*	$2,300 person / $4,600 family	$4,600 person / $9,200 family
Preventive care/screening/immunization	Covered in full	30% coinsurance after deductible is met
Doctor Home and Office Services		
Primary care visit to treat an injury or illness	$30 copay per visit	30% coinsurance after deductible is met
Specialist care visit	$45 copay per visit	30% coinsurance after deductible is met
Prenatal and Post-natal Care	20% coinsurance	30% coinsurance after deductible is met

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Other practitioner visits:		
Retail health clinic	$30 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.*	$30 PCP/$45 Spec. copay per visit	30% coinsurance after deductible is met
Other services in an office:		
Allergy testing	$45 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	20% coinsurance	30% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance	30% coinsurance after deductible is met

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X-ray:		
Office	20% coinsurance	30% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance	30% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance	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	20% coinsurance	30% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance	30% coinsurance after deductible is met
Emergency and Urgent Care		
Emergency room facility services	$100 copay plus 20% coinsurance per visit	Covered as In-Network
Emergency room doctor and other services	$30 PCP/$45 Spec. copay per visit	Covered as In-Network
Ambulance Transportation	20% coinsurance	Covered as In-Network
Urgent Care Center Office Visit	$45 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	$30 copay per visit	30% coinsurance after deductible is met
Facility visit: Facility fees	20% coinsurance	30% coinsurance after deductible is met
Doctor Services	20% coinsurance	30% coinsurance after deductible is met
Outpatient Surgery		
Facility fees:		
Hospital	$100 copay plus 20% coinsurance per visit	30% coinsurance after deductible is met
Freestanding Surgical Center	$100 copay plus 20% coinsurance per visit	30% coinsurance after deductible is met
Doctor and other services		
Surgery	$30 PCP/$45 Spec. 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)	$300 copay plus 20% coinsurance per admission	30% coinsurance after deductible is met
Doctor and other services	20% coinsurance	30% coinsurance after deductible is met

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Recovery & Rehabilitation		
Home health care (*Including separate Private Duty Nursing benefit, up to 16 hours per calendar year – 20% coinsurance)* *Coverage for In-Network and Non-Network Provider combined is limited to 90 visits per benefit period. Visit limit does not apply to Home Infusion Therapy or Home Dialysis.*	Covered in full	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.*	$45 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.*	$45 copay per visit plus 20% coinsurance	30% coinsurance after deductible is met

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.*	$45 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.*	$45 copay per visit plus 20% coinsurance	30% coinsurance after deductible is met
Cardiac rehabilitation Office Visit	20% coinsurance	30% coinsurance after deductible is met
Outpatient hospital	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 100 days per admission.*	Covered in full	30% coinsurance after deductible is met
Hospice	Covered in full	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

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Prescription Drug Benefits through OptumRx	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Tier 1	$10 copay per prescription (up to a 30 day supply retail). $20 copay per prescription (up to a 90 day supply home delivery only).	$10 copay per prescription (up to a 30 day supply retail). Mail order not covered.
Tier 2	$30 copay per prescription (up to a 30 day supply retail). $60 copay per prescription (up to a 90 day supply home delivery only).	$30 copay per prescription (up to a 30 day supply retail). Mail order not covered.
Tier 3	$45 copay per prescription (up to a 30 day supply retail). $90 copay per prescription (up to a 90 day supply home delivery only).	$45 copay per prescription (up to a 30 day supply retail). Mail order not covered.

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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 Medical coinsurance, copays and deductible count toward your out of pocket amount. Prescription drug copays do not count toward this out of pocket limit.
- 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 90 days 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 copays or coinsurance.
- 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.
- Outpatient Prescription Drugs are excluded from Anthem coverage, however offered through OptumRx.
- Routine Vision exams are excluded from coverage.

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)

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