

# Your summary of benefits

Anthem Blue Cross and Blue Shield

Your Contract Code: modified for Revature LLC 02 01 2019

Your Plan: Anthem KeyCare 500/20%/2400

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
<b>Overall Deductible</b> <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>	\$500 person / \$1,500 family	\$900 person / \$2,700 family
<b>Out-of-Pocket Limit</b> <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>	\$2,400 person / \$7,200 family	\$6,850 person / \$13,700 family
<b>Preventive care/screening/immunization</b> <i>In-network preventive care is not subject to deductible, if your plan has a deductible.</i>	No charge	40% coinsurance after deductible is met
<b>Doctor Home and Office Services</b>		
<b>Primary care visit to treat an injury or illness</b>	\$20 copay per visit	40% coinsurance after deductible is met
<b>Specialist care visit</b>	\$20 copay per visit	40% coinsurance after deductible is met
<b>Prenatal and Post-natal Care</b>	20% coinsurance after deductible is met	40% coinsurance after deductible is met

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<p><b>Other practitioner visits:</b> Retail health clinic</p> <p>On-line Medical Visit <i>Live Health Online is the preferred telehealth solutions (<a href="http://www.livehealthonline.com">www.livehealthonline.com</a>)</i></p> <p>Chiropractic services <i>Coverage for In-Network Provider and Non-Network Provider combined is limited to 30 visits for Rehabilitation and Habilitative per benefit period.</i></p>	<p>\$20 copay per visit</p> <p>\$10 copay per visit</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b>Other services in an office:</b> Allergy testing</p> <p>Chemo/radiation therapy</p> <p>Dialysis/Hemodialysis</p> <p>Prescription drugs <i>For the drugs itself dispensed in the office thru infusion/injection.</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b>Diagnostic Services</b></p> <p><b>Lab:</b> Office</p> <p>Preferred Reference Lab</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>

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Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>X-ray:</b>		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Advanced diagnostic imaging (for example, MRI/PET/CAT scans):</b>		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Emergency and Urgent Care</b>		
Emergency room facility services	\$150 copay per visit (waived if admitted)	Covered as In-Network
Emergency room doctor and other services	20% coinsurance after deductible is met	Covered as In-Network

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<p><b>Ambulance Transportation</b></p>	<p>20% coinsurance after deductible is met</p>	<p>Covered as In-Network</p>
<p><b>Urgent Care Center Office Visit</b></p>	<p>\$20 copay per visit</p>	<p>40% coinsurance after deductible is met</p>
<p><b>Outpatient Mental Health and Substance Use Disorder</b></p> <p><b>Doctor office visit and Online Visit</b></p> <p><b>Facility visit:</b> Facility fees</p> <p>Doctor Services</p>	<p>\$20 copay per visit</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b>Outpatient Surgery</b></p> <p><b>Facility fees:</b></p> <p>Hospital</p> <p>Freestanding Surgical Center</p> <p><b>Doctor and other services</b></p> <p>Surgery</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>

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<p><b>Hospital Stay (all inpatient stays including maternity, mental and substance use disorder)</b></p> <p><b>Facility fees (for example, room &amp; board)</b></p> <p><b>Doctor and other services</b></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b>Recovery &amp; Rehabilitation</b></p> <p><b>Home health care</b>  <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.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>
<p><b>Rehabilitation services (for example, physical/speech/occupational therapy):</b></p> <p><b>Office</b>  <i>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.</i></p> <p><b>Outpatient hospital</b>  <i>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.</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>

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<p><b>Habilitation services (for example, physical/speech/occupational therapy):</b></p> <p><b>Office</b>  <i>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.</i></p> <p><b>Outpatient hospital</b>  <i>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.</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b>Cardiac rehabilitation</b></p> <p>Office Visit</p> <p>Outpatient hospital</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b>Skilled nursing care (in a facility)</b>  <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>40% coinsurance after deductible is met</p>
<p><b>Hospice</b></p>	<p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>

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<b>Durable Medical Equipment</b>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Prosthetic Devices</b> <i>Coverage for wigs needed after cancer treatment In-Network and Non-Network Provider combined is limited to 1 unit per benefit period.</i>	20% coinsurance after deductible is met	40% 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
<b>Pharmacy Deductible</b>	Not Applicable	Not Applicable
<b>Pharmacy Out of Pocket</b>	Combined with medical out of pocket	Combined with medical out of pocket
<b>Prescription Drug Coverage</b> <i>Anthem Essential Drug List</i> <i>This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.</i>		
<b>Tier 1 - Typically Generic</b> <i>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.</i>	\$15 copay per prescription (retail only). \$30 copay per prescription (home delivery only).	40% coinsurance after deductible is met (retail) and Not covered (home delivery)
<b>Tier 2 - Typically Preferred Brand &amp; Non-Preferred Generics</b> <i>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.</i>	\$35 copay per prescription (retail only). \$70 copay per prescription (home delivery only).	40% coinsurance after deductible is met (retail) and Not covered (home delivery)
<b>Tier 3 - Typically Non-Preferred Brand</b> <i>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.</i>	\$60 copay per prescription (retail only). \$120 copay per prescription (home delivery only).	40% coinsurance after deductible is met (retail) and Not covered (home delivery)



# Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>Tier 4 - Typically Preferred Specialty (brand and generic)</b>  <i>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.</i></p>	<p>50% coinsurance up to \$100 (retail and home delivery).</p>	<p>40% coinsurance after deductible is met (retail) and Not covered (home delivery)</p>

# 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.</i></p>		
<p><b>Child Vision exam</b>  <i>Coverage for In-Network Providers is limited to 1 exam per benefit period.</i></p>	No charge	\$30 reimbursement
<p><b>Adult Vision exam</b>  <i>Coverage for In-Network Providers is limited to 1 exam per benefit period.</i></p>	\$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](http://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.

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Questions: Visit us at [www.anthem.com](http://www.anthem.com)

VA/L/Anthem KeyCare 1000/20%/5000/39G0/01-18

### 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.

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**Navajo (Diné):** Dii naaltsoos biká'ígíí lahgo bina'idilkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj' bee nił hodoonih t'áadoo bą́ą́h ilínígóó. Ata' halne'ígíí la' bich'i' hadeesdzih nínizingo koǰ' hodiilnih (844) 682-6553.

## Language Access Services:

**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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