Your summary of benefits

Anthem BlueCross BlueShield

Your Plan: Anthem Silver PPO 3500/0%/3500 w/HSA

Your Network: KeyCare

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal contract of coverage. If there is a difference between this summary and the contract of coverage, the contract of coverage will prevail.

Covered Medical Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
Overall Deductible *This is a non-embedded deductible plan. See notes section at the end of the document to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Retail Prescription Drug Coverage section.*	Single: $3,500 Per Family: $7,000	Single: $7,000 Per Family: $14,000
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 at the end of the document for additional information regarding your out of pocket maximum.* *For prescription drug, all cost shares count towards your plan's annual out-of-pocket limit.*	Single: $3,500 Per Family: $7,000	Single: $8,750 Per Family: $17,500
Doctor Home and Office Services		
Preventive care *In-network preventive care is not subject to deductible, if your plan has a deductible.*	Covered in full	30% coinsurance after deductible
Primary care visit to treat an injury or illness	0% coinsurance after deductible	30% coinsurance after deductible
Specialist care visit	0% coinsurance after deductible	30% coinsurance after deductible
Prenatal and post-natal care	0% coinsurance after deductible	30% coinsurance after deductible

Covered Medical Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
Doctor Home and Office Services (*continued*)		
Other practitioner visits:		
Retail health clinic	0% coinsurance after deductible	30% coinsurance after deductible
On-line visit	0% coinsurance after deductible	30% coinsurance after deductible
Chiropractor services *Limited to 30 visits per benefit period across outpatient and other professional visits.*	0% coinsurance after deductible	30% coinsurance after deductible
Other services in an office:		
Allergy testing	0% coinsurance after deductible	30% coinsurance after deductible
Chemo/radiation therapy	0% coinsurance after deductible	30% coinsurance after deductible
Hemodialysis	0% coinsurance after deductible	30% coinsurance after deductible
Prescription drugs	0% coinsurance after deductible	30% coinsurance after deductible

Covered Medical Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
Diagnostic Services		
Lab:		
Freestanding/Reference Labs	0% coinsurance after deductible	30% coinsurance after deductible
Office	0% coinsurance after deductible	30% coinsurance after deductible
Outpatient hospital	0% coinsurance after deductible	30% coinsurance after deductible
X-ray:		
Office	0% coinsurance after deductible	30% coinsurance after deductible
Freestanding radiology center	0% coinsurance after deductible	30% coinsurance after deductible
Outpatient hospital	0% coinsurance after deductible	30% coinsurance after deductible
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office	0% coinsurance after deductible	30% coinsurance after deductible
Freestanding radiology center	0% coinsurance after deductible	30% coinsurance after deductible
Outpatient hospital	0% coinsurance after deductible	30% coinsurance after deductible

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Emergency and Urgent Care		
Urgent care (office setting)	0% coinsurance after deductible	30% coinsurance after deductible
Emergency room facility services	0% coinsurance after deductible	Same as In Network
Emergency room doctor and other services	0% coinsurance after deductible	Same as In Network
Ambulance (air and ground)	0% coinsurance after deductible	Same as In Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit	0% coinsurance after deductible	30% coinsurance after deductible
Facility visit:		
Facility fees	0% coinsurance after deductible	30% coinsurance after deductible
Doctor services	0% coinsurance after deductible	30% coinsurance after deductible
Outpatient Surgery		
Facility fee:		
Freestanding surgical center	0% coinsurance after deductible	30% coinsurance after deductible
Hospital	0% coinsurance after deductible	30% coinsurance after deductible
Doctor services:		
Freestanding surgical center	0% coinsurance after deductible	30% coinsurance after deductible
Hospital	0% coinsurance after deductible	30% coinsurance after deductible

Anthem BlueCross BlueShield

Covered Medical Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse) **Facility fee (for example, room & board)**	0% coinsurance after deductible	30% coinsurance after deductible
Doctor and other services	0% coinsurance after deductible	30% coinsurance after deductible
Recovery & Rehabilitation **Home health care** *Limited to 100 visits per benefit period ; limit does not apply to Home Infusion Therapy or Home Dialysis. Private Duty Nursing Benefit Maximum is 16 hours per Benefit Period, In-and Out of Network combined*	0% coinsurance after deductible	30% coinsurance after deductible
Rehabilitation services **(for example, physical/speech/occupational therapy):** Office Outpatient hospital *Limited to 30 combined visits per benefit period for Physical & Occupational Therapy. Limited to 30 visits for Speech Therapy. Limits will not apply if care is received as part of hospice or home health.*	0% coinsurance after deductible 0% coinsurance after deductible	30% coinsurance after deductible 30% coinsurance after deductible
Cardiac rehabilitation Office Outpatient hospital	0% coinsurance after deductible 0% coinsurance after deductible	30% coinsurance after deductible 30% coinsurance after deductible
Skilled nursing care (in a facility) *Limited to 100 combined days per stay In & Out of Network combined for Physical Medicine and Rehab and Skilled Nursing Facility (includes services in an Outpatient Day Rehabilitation Program).*	0% coinsurance after deductible	30% coinsurance after deductible
Durable medical equipment & prosthetics	0% coinsurance after deductible	30% coinsurance after deductible

Covered Prescription Drug Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
Retail Prescription Drug Coverage ***This plan uses a Anthem National Drug List. Drugs not on the list are not covered.*** ***This plan includes Home Delivery (Mail Order).***		
Deductible *Your plan deductible applies to all pharmacy Tiers and both in-network and out-of-network services if your plan includes out-of-network coverage.*	Prescription Deductible (Member) : Combined with medical deductible Prescription Deductible (Family) : Combined with medical deductible	Prescription Deductible (Member) : Combined with medical deductible Prescription Deductible (Family) : Combined with medical deductible
Drug tier 1 - Typically Generic	0% coinsurance after deductible	30% coinsurance after deductible
Drug tier 2 - Typically Preferred / Formulary Brand	0% coinsurance after deductible	30% coinsurance after deductible
Drug tier 3 - Typically Non-preferred/Non-formulary and Specialty Drugs	0% coinsurance after deductible	30% coinsurance after deductible
Drug tier 4 - Typically Specialty Drugs	0% coinsurance after deductible	30% coinsurance after deductible

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Covered Vision Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-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. *Children's and adult vision services count towards your out of pocket limit.*	*For children through age 18, there is a selection of frames and contact lenses that are covered under this plan. Review the formal contract of coverage or contact your vision provider for more information.*	*For covered services with a reimbursement amount, you will have no cost share up to that amount. All costs beyond the reimbursement amount are subject to balance billing.*
Children's Vision Essential Health Benefits		
Vision exam	$0 copay	$30 reimbursement
Frames	$0 copay	$45 reimbursement
Lenses		
Single	$0 copay	$25 reimbursement
Bifocal	$0 copay	$40 reimbursement
Trifocal	$0 copay	$55 reimbursement
Elective Contact Lenses	$0 copay	$60 reimbursement
Non-Elective Contact Lenses	Covered in full	$210 reimbursement

Covered Vision Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
Adult Vision Essential Health Benefits		
Vision exam	$20 copay	$30 reimbursement
Frames	Not covered	Not covered
Lenses		
Single	Not covered	Not covered
Bifocal	Not covered	Not covered
Trifocal	Not covered	Not covered
Elective Contact Lenses	Not covered	Not covered
Non-Elective Contact Lenses	Not covered	Not covered

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Covered Dental Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
This is a brief outline of your dental 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. *Children's dental services count towards your out of pocket limit.*		
Children's Dental Essential Health Benefits **Diagnostic and preventive**	10% coinsurance	30% coinsurance
Basic services	40% coinsurance after deductible	50% coinsurance after deductible
Major services	50% coinsurance after deductible	50% coinsurance after deductible
Medically Necessary Orthodontia services	50% coinsurance after deductible	50% coinsurance after deductible
Cosmetic Orthodontia services	Not covered	Not covered
Deductible (Applies to all services except diagnostic & preventive)	Combined with Medical	Combined with Medical
Out-of-Pocket Limit	Combined with Medical	Combined with Medical
Adult Dental Essential Health Benefits **Diagnostic and preventive**	Not covered	Not covered
Basic services	Not covered	Not covered
Major services	Not covered	Not covered
Deductible	Not covered	Not covered
Out-of-Pocket Limit	Not covered	Not covered

Your plan also includes the following Clinical Program Incentives	
Condition Care incentives (Asthma, COPD, CAD, CHF, Diabetes)	$300/year
Future Mom incentives	$200/year
Healthy Lifestyles Online incentives	$150 / year

Notes:

- Vision services are not subject to the annual deductible.
- This plan has a non-embedded deductible. A non-embedded deductible is a deductible that must be satisfied for the coverage level selected before cost-sharing begins. For example, if family coverage exists, then the family deductible must be met by one or all members in order for family cost sharing to begin.
- 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 an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay 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.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.
- 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.
- Your copays, coinsurance and deductible count toward your out of pocket amount.
- Wigs needed after cancer treatment is limited to one wig per benefit period.
- Private Duty Nursing at home is limited to 16 hours per benefit period
- For additional information on limitations and exclusions that apply to this plan, go to sgplans.anthem.com/va/le/bcbs
- For additional information on this plan, please visit sbc.anthem.com to obtain a “Summary of Benefit Coverage”.