

# Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Contract Code: 3UJD

Your Plan: KeyCare 750 with RX

Your Network: KeyCare

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b>	\$750 person / \$1,500 family	\$750 person / \$1,500 family
<b>Out-of-Pocket Limit</b>	\$3,050 person / \$6,100 family	\$4,300 person / \$8,600 family
<p>The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per person out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the per person deductible or per person out-of-pocket maximum.</p> <p>Your copays, coinsurance and deductible count toward your out of pocket amount(s).</p> <p>In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other.</p>		
<b>Preventive Care / Screening / Immunization</b>	No charge	40% coinsurance after medical deductible is met
<b>Preventive Care for Chronic Conditions</b> <i>per IRS guidelines</i>	No charge	40% coinsurance after medical deductible is met
<p><b><u>Virtual Care (Telemedicine / Telehealth Visits)</u></b></p> <p><b>Virtual Visits - Online visits with Doctors who also provide services in person</b></p>		
Primary Care (PCP)	\$25 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Mental Health and Substance Abuse care	\$25 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met

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VA/LG/3UJG/01-01-2025

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Specialist	\$50 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
<p><b>Virtual Visits from Online Provider LiveHealth Online</b> via <a href="http://www.livehealthonline.com">www.livehealthonline.com</a>; our mobile app, website or Anthem-enabled device</p> <p>Primary Care (PCP) and Mental Health and Substance Abuse</p> <p>Specialist Care</p>	No charge	\$50 copay per visit medical deductible does not apply
<p><b><u>Visits in an Office</u></b></p> <p><b>Primary Care (PCP)</b></p> <p><b>Specialist Care</b></p>	<p>\$25 copay per visit medical deductible does not apply</p> <p>\$50 copay per visit medical deductible does not apply</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>
<p><b><u>Other Practitioner Visits</u></b></p> <p><b>Routine Maternity Care</b> (Prenatal and Postnatal)</p> <p><b>Retail Health Clinic</b></p> <p><b>Manipulation Therapy</b> <i>Coverage is limited to 30 visits per year.</i></p>	<p>20% coinsurance after medical deductible is met</p> <p>\$25 copay per visit medical deductible does not apply</p> <p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>
<p><b><u>Other Services in an Office</u></b></p> <p><b>Allergy Testing</b></p> <p><b>Chemo/Radiation Therapy</b></p>	<p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>Dialysis/Hemodialysis</b></p> <p><b>Prescription Drugs</b> <i>Dispensed in the office</i></p> <p><b>Surgery</b></p>	<p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>
<p><b><u>Diagnostic Services</u></b></p> <p><b>Lab</b></p> <p>Office</p> <p>Preferred Reference Lab</p> <p>Outpatient Hospital</p>	<p>No charge</p> <p>No charge</p> <p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>
<p><b>X-Ray</b></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>
<p><b>Advanced Diagnostic Imaging</b> <i>for example: MRI, PET and CAT scans</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b><u>Emergency and Urgent Care</u></b></p> <p><b>Urgent Care</b></p> <p><b>Emergency Room Facility Services</b> <i>Copay waived if admitted.</i></p> <p><b>Emergency Room Doctor and Other Services</b></p> <p><b>Ambulance</b></p>	<p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p><b><u>Outpatient Mental Health and Substance Abuse</u></b></p> <p><b>Doctor Office Visit</b></p> <p><b>Facility Visit</b></p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>\$25 copay per visit medical deductible does not apply</p> <p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>
<p><b><u>Outpatient Surgery</u></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>Hospital</p>	<p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b><u>Hospital (Including Maternity, Mental Health and Substance Abuse)</u></b></p> <p><b>Facility Fees</b></p> <p><b>Doctor and other services</b></p>	<p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>
<p><b><u>Recovery &amp; Rehabilitation</u></b></p> <p><b>Home Health Care</b> <i>Coverage is limited to 90 visits per benefit period.</i></p>	<p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p>
<p><b>Rehabilitation services</b> <i>Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 60 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>
<p><b>Cardiac rehabilitation</b></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>
<p><b>Skilled Nursing Care (facility)</b> <i>100 days combined per stay.</i></p>	<p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p>
<p><b>Inpatient Hospice</b></p>	<p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Durable Medical Equipment</b>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<b>Prosthetic Devices</b> <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	20% coinsurance after medical deductible is met	40% 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
<b>Pharmacy Deductible</b>	Not applicable	Not applicable
<b>Pharmacy Out-of-Pocket Limit</b>	\$3,500 person/ \$7,000 family	Not applicable
<b>Prescription Drug Coverage</b> <i>Cost shares for drugs included on the National drug list appear below. Your plan uses the Base Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply. Drug cost share assistance programs may be available for certain specialty drugs.</i>		
<b>Home Delivery Pharmacy</b> <i>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. Optional Home Delivery</i>		
<b>Tier 1 - Typically Generic</b> <i>Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</i>	\$15 copay per prescription, deductible does not apply (retail) and \$30 copay per prescription, deductible does not apply (home delivery)	\$15 copay per prescription, deductible does not apply (retail) and Not covered (home delivery)
<b>Tier 2 – Typically Preferred Brand</b> <i>Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</i>	\$40 copay per prescription, deductible does not apply (retail) and \$80 copay per prescription, deductible does not apply (home delivery)	\$40 copay per prescription, deductible does not apply (retail) and Not covered (home delivery)
<b>Tier 3 - Typically Non-Preferred Brand</b> <i>Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</i>	\$75 per prescription, deductible does not apply (retail) and \$150	\$75 per prescription, deductible does not apply (retail) and Not

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
	per prescription, deductible does not apply (home delivery)	covered (home delivery)
<b>Tier 4 - Typically Specialty (brand and generic)</b> <i>Per 30 day supply (specialty pharmacy).</i>	20% coinsurance up to \$200 per prescription, deductible does not apply (retail)	Not covered (retail and home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<i>This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.</i>		
<b><u>Children's Vision (up to age 19)</u></b> <b>Vision exam</b> <i>Limited to 1 exam per year</i>	\$15 copay deductible does not apply	\$30 allowance
<b><u>Adult Vision (age 19 and older)</u></b> <b>Vision exam</b> <i>Limited to 1 exam per year</i>	\$15 copay deductible does not apply	Reimbursed Up to \$30

**Notes:**

- 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 to the applicable Anthem enrollment brochure.*

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### 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 (833) 621-0308

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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## Language Access Services:

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