

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Contract Code: 49EG

Your Plan: Pittsylvania County and Schools: Anthem HSA Embedded

Your Network: KeyCare

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge after deductible is met
Mental Health & Substance Use Disorder Services	No charge after deductible is met
Specialist care	No charge after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$3,500 person / \$7,000 family	\$3,500 person / \$7,000 family
Overall Out-of-Pocket Limit	\$4,500 person / \$9,000 family	\$7,000 person / \$14,000 family

The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit.

All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit (excluding Non-Network Human Organ and Tissue Transplant (HOTT), Cellular and Gene Therapy services).

In-Network and Non-Network deductibles are combined and accumulate toward each other; however In-Network and Non-Network out-of-pocket limit amounts accumulate separately and do not accumulate toward each other.

Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*

Primary Care (PCP) and Mental Health and Substance Use Disorder Services <i>virtual and office</i>	No charge after deductible is met	20% coinsurance after deductible is met
Specialist Care <i>virtual and office</i>	No charge after deductible is met	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><u>Other Practitioner Visits</u></p> <p>Routine Maternity Care (Prenatal and Postnatal)</p> <p>Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i></p> <p>Manipulation Therapy <i>Coverage is limited to 30 visits per benefit period.</i></p>	<p>No charge after deductible is met</p> <p>No charge after deductible is met</p> <p>No charge 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><u>Other Services in an Office</u></p> <p>Allergy Testing</p> <p>Prescription Drugs <i>Dispensed in the office</i></p> <p>Surgery</p>	<p>No charge after deductible is met</p> <p>No charge after deductible is met</p> <p>No charge 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>Preventive care / screenings / immunizations</p>	<p>No charge</p>	<p>20% coinsurance after deductible is met</p>
<p>Preventive Care for Chronic Conditions <i>per IRS guidelines</i></p>	<p>No charge</p>	<p>20% coinsurance after deductible is met</p>
<p><u>Diagnostic Services</u></p> <p>Lab</p> <p>Office</p> <p>Preferred Reference Lab</p> <p>Outpatient Hospital</p>	<p>No charge after deductible is met</p> <p>No charge after deductible is met</p> <p>No charge 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>X-Ray</p> <p>Office</p> <p>Outpatient Hospital</p>	<p>No charge after deductible is met</p> <p>No charge after deductible is met</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>
<p>Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i></p> <p>Office</p>	<p>No charge after deductible is met</p>	<p>20% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	No charge after deductible is met	20% coinsurance after deductible is met
<u>Emergency and Urgent Care</u> Urgent Care Emergency Room Facility Services Emergency Room Doctor and Other Services Ambulance	No charge after deductible is met No charge after deductible is met No charge after deductible is met No charge after deductible is met	20% coinsurance after deductible is met Covered as In-Network Covered as In-Network Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility Facility Fees Doctor Services	No charge after deductible is met No charge after deductible is met	20% coinsurance after deductible is met 20% coinsurance after deductible is met
<u>Outpatient Surgery</u> Facility Fees Hospital Ambulatory Surgical Center Physician and other services including surgeon fees Hospital	No charge after deductible is met No charge after deductible is met No charge after deductible is met	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met
<u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u> Facility Fees Physician and other services including surgeon fees	No charge after deductible is met No charge after deductible is met	20% coinsurance after deductible is met 20% coinsurance after deductible is met
Home Health Care <i>Coverage is limited to 100 visits per benefit period.</i>	No charge after deductible is met	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies.</i> <i>Coverage for physical and occupational therapies is limited to 30 visits combined per benefit period. Coverage for speech therapy is limited to 30 visits per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>No charge after deductible is met</p> <p>No charge after deductible is met</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>
<p>Pulmonary rehabilitation <i>office and outpatient hospital</i></p>	<p>No charge after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p>Cardiac rehabilitation <i>office and outpatient hospital</i></p>	<p>No charge after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p>Dialysis/Hemodialysis <i>office and outpatient hospital</i></p>	<p>No charge after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p>Chemo/Radiation Therapy <i>office and outpatient hospital</i></p>	<p>No charge after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p>Skilled Nursing Care (facility) <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 100 days combined per admission.</i></p>	<p>No charge after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p>Inpatient Hospice</p>	<p>No charge after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p>Durable Medical Equipment</p>	<p>No charge after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p>Prosthetic Devices <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i></p>	<p>No charge after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p>Hearing Aids <i>Coverage is limited to 1 item per ear up to \$1,500 per ear, every 24 months for members through age 18.</i></p>	<p>No charge after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<p>Pharmacy Deductible</p>	<p>Combined with In-Network medical deductible</p>	<p>Combined with Non-Network medical deductible</p>

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
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 Network: Base Network Drug List: Essential <i>Drugs not included on the Essential drug list will not be covered.</i>		
Day Supply Limits: Retail Pharmacy <i>30 day supply (cost shares noted below)</i> Retail 90 Pharmacy <i>90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).</i> Home Delivery Pharmacy <i>90 day supply (maximum cost shares noted below). Maintenance medications are available through CarelonRx Pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.</i> Specialty Pharmacy <i>30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy. Drug cost share assistance programs may be available for certain specialty drugs.</i>		
Preventive Drugs <i>No deductible, copayment or coinsurance applies to prescription drugs on the PreventiveRX Enhanced drug list when you use an In-Network Pharmacy.</i>		
Tier 1 - Typically Generic	\$10 copay per prescription after deductible is met (retail) and \$25 copay per prescription after deductible is met (home delivery)	\$10 copay per prescription after deductible is met (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand	\$40 copay per prescription after deductible is met (retail) and \$100 copay per prescription after deductible is met (home delivery)	\$40 copay per prescription after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	\$60 copay per prescription after deductible is met (retail) and \$150 copay per prescription after deductible is met (home delivery)	\$60 copay per prescription after deductible is met (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	20% coinsurance up to \$250 per prescription after deductible is met (retail and home	Not covered (retail and home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
	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>		
Children's Vision exam (up to age 19) <i>Limited to 1 exam per benefit period.</i>	\$15 copay deductible does not apply	Reimbursed Up to \$30
Adult Vision exam (age 19 and older) <i>Limited to 1 exam per benefit period.</i>	\$15 copay deductible does not apply	Reimbursed Up to \$30

Notes:

- 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.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.

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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Questions: (833) 592-9956 or visit us at www.anthem.com

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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 (833) 592-9956

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 (833) 592-9956

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (833) 592-9956:

Chinese(中文): 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(833) 592-9956。

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French (Français): Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (833) 592-9956.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (833) 592-9956.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (833) 592-9956.

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(833) 592-9956 にお電話ください。

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(833) 592-9956로 문의하십시오.

Navajo (Diné): Díí naaltsoos biká'ígíí lahgo bina'ídiłkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj bee níl hodoonih t'áadoo báąh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih nínízingo kojí' hodiłlnih (833) 592-9956.

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: (833) 592-9956.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਬਾਰੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (833) 592-9956 ਤੇ ਕਾਲ ਕਰੋ।

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (833) 592-9956.

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It's important we treat you fairly

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