

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Franklin County Public Schools

Your Contract Code: 36SK Custom

07/01/2023 – 06/30/2024

Your Plan: Anthem KeyCare 30 1000/20%/4500 Rx \$10/\$40/\$60/20%

Your Network: KeyCare

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$1,000 person / \$2,000 family	\$2,000 person / \$4,000 family
Overall Out-of-Pocket Limit	\$4,500 person / \$9,000 family	\$11,250 person / \$22,500 family
<p>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.</p> <p>Your copays, coinsurance and deductible count toward your out of pocket limit(s).</p> <p>In-Network and Non-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.</p>		
Doctor Visits (virtual and office) <i>You are encouraged to select a Primary Care Physician (PCP).</i>		
Medical Chats and Virtual Visits for Primary Care <i>from our Online Provider K Health, through its affiliated Provider groups are covered at \$0 copay per visit medical deductible does not apply.</i>		
Virtual Visits from online provider LiveHealth Online <i>for urgent/acute medical and mental health and substance abuse care via www.livehealthonline.com are covered at \$0 copay per visit medical deductible does not apply; and \$50 copay per visit medical deductible does not apply for covered Specialist Care.</i>		
Preferred PCP <i>virtual and office</i>	\$20 copay per visit medical deductible does not apply	Not covered
Primary Care (PCP) <i>virtual and office</i>	\$30 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met

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

VA/LG/Anthem KeyCare 30 1000/20%/4500 Rx \$10/\$40/\$60/20%/Custom/07-01-2023

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Mental Health and Substance Abuse Care <i>virtual and office</i>	\$30 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Specialist Care <i>virtual and office</i>	\$50 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
<u>Other Practitioner Visits</u>		
Routine Maternity Care (Prenatal and Postnatal)	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i>	\$30 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Manipulation Therapy <i>Coverage is limited to 30 visits per benefit period.</i>	\$30 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
<u>Other Services in an Office</u>		
Allergy Testing	\$20 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Prescription Drugs <i>Dispensed in the office</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Surgery	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Preventive care / screenings / immunizations	No charge	40% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	40% coinsurance after medical deductible is met
<u>Diagnostic Services</u>		
Lab		
Office	No charge	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Preferred Reference Lab	No charge	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
X-Ray		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i>		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<u>Emergency and Urgent Care</u>		
Urgent Care <i>includes doctor services. Additional charges may apply depending on the care provided.</i>	\$50 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Emergency Room Facility Services	20% coinsurance after medical deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after medical deductible is met	Covered as In-Network
Ambulance	20% coinsurance after medical deductible is met	Covered as In-Network
<u>Outpatient Mental Health and Substance Abuse Care at a Facility</u>		
Facility Fees	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Doctor Services	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<u>Outpatient Surgery</u> Facility Fees Hospital Ambulatory Surgical Center Doctor and Other Services Hospital	20% coinsurance after medical deductible is met \$300 copay per visit medical deductible does not apply 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
<u>Hospital (Including Maternity, Mental Health and Substance Abuse)</u> Facility Fees Physician and other services <i>including surgeon fees</i>	20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
Home Health Care <i>Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
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> Office Outpatient Hospital	\$30 copay per visit medical deductible does not apply 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pulmonary rehabilitation <i>office and outpatient hospital</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Cardiac rehabilitation <i>office and outpatient hospital</i> <i>Coverage is limited to 36 visits per benefit period.</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Dialysis/Hemodialysis <i>office and outpatient hospital</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Chemo/Radiation Therapy <i>office and outpatient hospital</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Skilled Nursing Care (facility) <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Inpatient Hospice	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Durable Medical Equipment	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prosthetic Devices <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
Pharmacy Deductible	Not applicable	Not applicable
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: <i>Base Network</i> Drug List: <i>Essential</i> Drugs not included on the Essential drug list will not be covered.		
Day Supply Limits:		

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<p>Retail Pharmacy 30 day supply (cost shares noted below)</p> <p>Retail 90 Pharmacy 90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).</p> <p>Home Delivery Pharmacy 90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail (IngenioRx will become CarelonRx on January 1, 2023). You will need to call us on the number on your ID card to sign up when you first use the service. Home Delivery is an optional service on this plan.</p> <p>Specialty Pharmacy 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.</p>		
Tier 1 - Typically Generic	\$10 copay per prescription, deductible does not apply (retail) and \$25 copay per prescription, deductible does not apply (home delivery)	40% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand	\$40 copay per prescription, deductible does not apply (retail) and \$100 copay per prescription, deductible does not apply (home delivery)	40% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	\$60 copay per prescription, deductible does not apply (retail) and \$150 copay per prescription, deductible does not apply (home delivery)	40% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	20% coinsurance up to \$250 per prescription, deductible does not apply (retail and home delivery)	40% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

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 representations of benefits in this document are subject to Virginia Bureau of Insurance (BOI) approval and are subject to change.

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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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。

Farsi (فارسی): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (833) 592-9956 تماس بگیرید.

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.

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Language Access Services:

Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'ídiikidgo ná bohónéedzǫ́ dóó bee ahóót'i' t'áá ni nizaad k'ehǫ́ bee níl hodoonih t'áadoo bááh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih nínízingo kojí' hodiílnih (833) 592-9956.

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.

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It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.