

# Your summary of benefits

Virginia United Methodist Conference

Your Plan: HSA \$2,250/20%

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.*

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.</i>	\$2,250 person / \$4,500 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>	\$5,500 person / \$11,000 family	
<b>Preventive care/screening/immunization</b> <i>In-network preventive care is not subject to deductible..</i>	\$0 copay; 0% coinsurance	50% coinsurance after deductible
<b>Doctor Home and Office Services</b>  <b>Primary care visit to treat an injury or illness</b>	20% coinsurance after deductible	50% coinsurance after deductible
<b>Specialist care visit</b>	20% coinsurance after deductible	50% coinsurance after deductible
<b>Prenatal and Post-natal Care</b>	20% coinsurance after deductible	50% coinsurance after deductible

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<p><b>Other practitioner visits:</b></p> <p><b>On-line Medical Visit</b>  <i>Live Health Online is the preferred telehealth solutions (<a href="http://www.livehealthonline.com">www.livehealthonline.com</a>) Coverage available for Primary Care Provider (PCP) and Mental Health visits. See mental health section for cost share.</i></p> <p><b>Chiropractic services</b>  <i>Limited to 30 visits per calendar year.</i></p>	<p>\$49 copay</p> <p>20% coinsurance after deductible</p>	<p>Not Covered</p> <p>50% coinsurance after deductible</p>
<p><b>Other services in an office:</b></p> <p>Allergy testing /Treatment</p> <p>Chemo/Radiation therapy</p> <p>Dialysis/Hemodialysis</p>	<p>20% coinsurance after deductible</p> <p>20% coinsurance after deductible</p> <p>20% coinsurance after deductible</p>	<p>50% coinsurance after deductible</p> <p>50% coinsurance after deductible</p> <p>50% coinsurance after deductible</p>
<p><b>Diagnostic Services</b></p> <p><b>Lab:</b> Office /Preferred Lab /Outpatient Hospital</p>	<p>20% coinsurance after deductible</p>	<p>50% coinsurance after deductible</p>
<p><b>X-ray:</b> Office /Freestanding Center /Outpatient Hospital</p>	<p>20% coinsurance after deductible</p>	<p>50% coinsurance after deductible</p>
<p><b>Advanced diagnostic imaging (ex: MRI/PET/CAT scans):</b> Office /Freestanding Radiology Center/ Outpatient Hospital</p>	<p>20% coinsurance after deductible</p>	<p>50% coinsurance after deductible</p>
<p><b>Emergency and Urgent Care</b></p> <p><b>Emergency room facility services</b></p> <p><b>Emergency room doctor and other services</b></p>	<p>20% coinsurance after deductible</p> <p>20% coinsurance after deductible</p>	<p>Covered as In-Network</p> <p>Covered as In-Network</p>

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<b>Ambulance Transportation</b>	20% coinsurance after deductible	Covered as In-Network
<b>Urgent Care Center Office Visit</b>	20% coinsurance after deductible	50% coinsurance after deductible
<b>Outpatient Mental Health and Substance Use Disorder</b>		
<b>Doctor Office Visit and Online (<i>LiveHealth Online</i>) Visit</b>	20% coinsurance after deductible	50% coinsurance after deductible
<b>Facility visit:</b>		
Facility fees	20% coinsurance after deductible	50% coinsurance after deductible
Doctor Services	20% coinsurance after deductible	50% coinsurance after deductible
<b>Outpatient Surgery</b>		
<b>Facility fees:</b>		
Hospital /Freestanding Surgical Center	20% coinsurance after deductible	50% coinsurance after deductible
<b>Doctor and other services</b>		
Surgery	20% coinsurance after deductible	50% coinsurance after deductible
<b>Hospital Stay (all inpatient stays including maternity, mental and substance use disorder)</b>		
<b>Facility fees (for example, room &amp; board)</b>	20% coinsurance after deductible	50% coinsurance after deductible
<b>Doctor and other services</b> <i>Including global maternity fee</i>	20% coinsurance after deductible	50% coinsurance after deductible

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<b>Recovery &amp; Rehabilitation</b> <b>Home health care</b> <i>In-Network and Non-Network Provider combined limited of 100 visits per calendar year.</i>	20% coinsurance after deductible	Not covered
<b>Rehabilitation services (physical/speech/occupational therapy):</b>  <b>Office /Outpatient hospital</b> <i>No visit limits.</i>	20% coinsurance after deductible	50% coinsurance after deductible
<b>Cardiac rehabilitation</b> Office Visit /Outpatient hospital  Outpatient hospital	20% coinsurance after deductible  20% coinsurance after deductible	50% coinsurance after deductible  50% coinsurance after deductible
<b>Skilled nursing care (in a facility)</b> <i>Limited to 100 days per admission.</i>	20% coinsurance after deductible	Not covered
<b>Hospice</b>	20% coinsurance after deductible	50% coinsurance after deductible
<b>Durable Medical Equipment</b>	20% coinsurance after deductible	50% coinsurance after deductible
<b>Prosthetic Devices</b>	20% coinsurance after deductible	50% coinsurance after deductible
<b>Vision routine exam</b> <i>Separate vision plan is available for all routine vision exam and materials</i>	Not covered	Not covered

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Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Pharmacy Deductible</b>	Combined with medical deductible	Combined with medical deductible
<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 National Drug Formulary</i> <i>Member must file claim for out-of-network reimbursement</i>		
<b>Tier 1 - Typically Generic</b> <i>Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program.) No coverage for non-formulary drugs.</i>	20% coinsurance after deductible	20% coinsurance after deductible (retail). No coverage (home delivery).
<b>Tier 2 - Typically Preferred Brand &amp; Non-Preferred Generics</b> <i>Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program.) No coverage for non-formulary drugs.</i>	20% coinsurance after deductible	20% coinsurance after deductible (retail). No coverage (home delivery).
<b>Tier 3 - Typically Non-Preferred Brand/Specialty (brand/generic)</b> <i>Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program.) No coverage for non-formulary drugs.</i>	20% coinsurance after deductible	20% coinsurance after deductible (retail). No coverage (home delivery).

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## Notes:

- The family deductible and out-of-pocket maximum are non-embedded meaning the cost shares of all family members apply to the family deductible and family out of pocket maximum. If you cover family members, the family deductible must be met before the coinsurance applies. The family out of pocket must be met before the plan starts paying in full.
- Your coinsurance, copays and deductible count toward your out of pocket amount.
- 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 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 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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