

Your summary of benefits

Virginia United Methodist Conference

Your Plan: PPO Buy-up \$750/20%

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
Overall Deductible <i>See notes section to understand how your deductible works.</i>	\$750 person / \$1,875 family	\$1,250 person / \$3,125 family
Out-of-Pocket Limit <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>	\$4,500 person / \$9,000 family	
Preventive care/screening/immunization <i>In-network preventive care is not subject to deductible.</i>	\$0 copay; 0% coinsurance	40% coinsurance after deductible is met
Doctor Home and Office Services		
Primary care visit to treat an injury or illness	\$20 copay	40% coinsurance after deductible
Specialist care visit	\$30 copay	40% coinsurance after deductible
Prenatal and Post-natal Care <i>Initial visit only. See Inpatient Services for Global delivery benefit</i>	\$20 or \$30 copay	40% coinsurance after deductible

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<p>Other practitioner visits:</p> <p>On-line Medical Visit <i>Live Health Online is the preferred telehealth solutions</i> www.livehealthonline.com</p> <p>Chiropractic services <i>Limited to 30 visits per calendar year</i></p>	<p>\$10 copay</p> <p>20% coinsurance after deductible</p>	<p>40% coinsurance after deductible</p> <p>40% coinsurance after deductible</p>
<p>Other services in an office:</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>40% coinsurance after deductible</p> <p>40% coinsurance after deductible</p> <p>40% coinsurance after deductible</p>
<p>Diagnostic Services</p> <p>Lab: Office /Preferred Reference Lab /Outpatient Hospital</p>	<p>20% coinsurance after deductible</p>	<p>40% coinsurance after deductible</p>
<p>X-ray: Office /Freestanding Radiology Center /Outpatient Hospital</p>	<p>20% coinsurance after deductible</p>	<p>40% coinsurance after deductible</p>
<p>Advanced diagnostic imaging (for example, MRI/PET/CAT scans): Office /Freestanding Radiology Center /Outpatient Hospital</p>	<p>20% coinsurance after deductible</p>	<p>40% coinsurance after deductible</p>
<p>Emergency and Urgent Care</p> <p>Emergency room facility services</p>	<p>\$150 copay</p>	<p>Paid as In-network</p>

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Emergency room doctor and other services	20% coinsurance after deductible	Paid as In-network
Ambulance Transportation	20% coinsurance after deductible	20% coinsurance after deductible
Urgent Care Center Office Visit	\$30 copay	40% coinsurance after deductible
Outpatient Mental Health and Substance Use Disorder		
Doctor Office Visit and Online (<i>LiveHealth Online</i>) Visit	\$0 copay; 0% coinsurance	40% coinsurance after deductible
Facility visit: Facility fees /Doctor Services	\$0 copay; 0% coinsurance	40% coinsurance after deductible
Outpatient Surgery		
Facility fees:		
Hospital	20% coinsurance after deductible	40% coinsurance after deductible
Freestanding Surgical Center	20% coinsurance after deductible	40% coinsurance after deductible
Doctor and other services		
Surgery	20% coinsurance after deductible	40% coinsurance after deductible
Hospital Stay (all inpatient stays including maternity, mental and substance use disorder)		
Facility fees (for example, room & board)	20% coinsurance after deductible	40% coinsurance after deductible
Doctor and other services Including global maternity fee	20% coinsurance after deductible	40% coinsurance after deductible

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Recovery & Rehabilitation Home health care <i>Coverage for In-Network and Non-Network Provider combined is limited to 100 visits per calendar year.</i>	20% coinsurance after deductible	40% coinsurance after deductible
Rehabilitation services (for example, physical/speech/occupational therapy): Office /Outpatient hospital <i>No visit limits</i>	20% coinsurance after deductible	40% coinsurance after deductible
Cardiac rehabilitation Office Visit Outpatient hospital	20% coinsurance after deductible 20% coinsurance after deductible	40% coinsurance after deductible 40% coinsurance after deductible
Skilled nursing care (in a facility) <i>Limited to 100 days per admission.</i>	20% coinsurance after deductible	40% coinsurance after deductible
Hospice	0% coinsurance	40% coinsurance after deductible
Durable Medical Equipment	20% coinsurance after deductible	40% coinsurance after deductible
Prosthetic Devices	20% coinsurance after deductible	40% coinsurance after deductible
Vision routine exam <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
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out of Pocket	Combined with medical out of pocket	Combined with medical out of pocket
Prescription Drug Coverage <i>Anthem National Drug Formulary</i> <i>Member must file claim for out-of-network reimbursement</i>		
Tier 1 - Typically Generic <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>	\$15 copay per prescription (retail). \$30 copay per prescription (home delivery).	\$15 copay per prescription (retail). No coverage (home delivery).
Tier 2 - Typically Preferred Brand & Non-Preferred Generics <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>	\$30 copay per prescription (retail). \$60 copay per prescription (home delivery).	\$30 copay per prescription (retail). No coverage (home delivery).
Tier 3 - Typically Non-Preferred Brand/Specialty (brand/generic) <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>	\$50 copay per prescription (retail). \$100 copay per prescription (home delivery).	\$50 copay per prescription (retail). No coverage (home delivery).

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Notes:

- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.
- Your coinsurance, copays and deductible count toward your out of pocket amount.
- For additional information on this plan, please visit sbc.anthem.com to obtain a "Summary of Benefit Coverage".
- All medical services subject to a coinsurance are also subject to the annual medical deductible.
- 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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Questions: Visit us at www.anthem.com

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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) 630-6742.

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(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) 630-6742.

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար գանգառեք հետևյալ հեռախոսահամարով՝ (833) 630-6742:

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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) 630-6742.

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Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'idiikidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj bee nił hodoonih t'áadoo bááh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih nínizingo kojí' hodíílnih (833) 630-6742.

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