Your summary of benefits

Anthem BlueCross BlueShield

Virginia United Methodist Conference

Your Plan: PPO Core $1,000/20%

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 *See notes section to understand how your deductible works.*	$1,000 person / $2,500 family	$1,500 person / $3,750 family
Out-of-Pocket Limit *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.*	$6,500 person / $13,000 family	
Preventive care/screening/immunization *In-network preventive care is not subject to deductible.*	$0 copay; 0% coinsurance	40% coinsurance after deductible is met
Doctor Home and Office Services		
Primary care visit to treat an injury or illness	$30 copay	40% coinsurance after deductible
Specialist care visit	$50 copay	40% coinsurance after deductible
Prenatal and Post-natal Care *Initial visit only. See Inpatient Services for Global delivery benefit*	$30 or $50 copay	40% coinsurance after deductible

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

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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	$50 copay	40% coinsurance after deductible
Outpatient Mental Health and Substance Use Disorder		
Doctor Office Visit and Online *(LiveHealth Online)* 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 *Coverage for In-Network and Non-Network Provider combined is limited to 100 visits per calendar year.*	20% coinsurance after deductible	40% coinsurance after deductible
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office /Outpatient hospital *No visit limits*	20% coinsurance after deductible	40% coinsurance after deductible
Cardiac rehabilitation		
Office Visit	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient hospital	20% coinsurance after deductible	40% coinsurance after deductible
Skilled nursing care (in a facility) *Limited to 100 days per admission.*	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 *Separate vision plan is available for all routine vision exam and materials*	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 *Anthem National Drug Formulary* *Member must file claim for out-of-network reimbursment*		
Tier 1 - Typically Generic *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.*	$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 *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.*	$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) *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.*	$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.

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) 630-6742.

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 630-6742 (833).

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) 630-6742:

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Farsi (فارسي): 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) 630-6742 تماس بگیرید.

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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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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) 630-6742 にお電話ください。

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Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bína'ídiłkidgo ná bohónéedzą́ dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínízingo kojį' hodíílnih (833) 630-6742.

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) 630-6742.

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Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (833) 630-6742.

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