Your summary of benefits

Anthem BlueCross BlueShield

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
Overall Deductible ***See notes section to understand how your deductible works.***	$2,250 person / $4,500 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.*	$5,500 person / $11,000 family	
Preventive care/screening/immunization *In-network preventive care is not subject to deductible..*	$0 copay; 0% coinsurance	50% coinsurance after deductible
Doctor Home and Office Services		
Primary care visit to treat an injury or illness	20% coinsurance after deductible	50% coinsurance after deductible
Specialist care visit	20% coinsurance after deductible	50% coinsurance after deductible
Prenatal and Post-natal Care	20% coinsurance after deductible	50% coinsurance after deductible

Your summary of benefits

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

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Ambulance Transportation	20% coinsurance after deductible	Covered as In-Network
Urgent Care Center Office Visit	20% coinsurance after deductible	50% coinsurance after deductible
Outpatient Mental Health and Substance Use Disorder		
Doctor Office Visit and Online *(LiveHealth Online)* Visit	20% coinsurance after deductible	50% coinsurance after deductible
Facility visit:		
Facility fees	20% coinsurance after deductible	50% coinsurance after deductible
Doctor Services	20% coinsurance after deductible	50% coinsurance after deductible
Outpatient Surgery		
Facility fees:		
Hospital /Freestanding Surgical Center	20% coinsurance after deductible	50% coinsurance after deductible
Doctor and other services **S**urgery	20% coinsurance after deductible	50% 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	50% coinsurance after deductible
Doctor and other services *Including global maternity fee*	20% coinsurance after deductible	50% coinsurance after deductible

Your summary of benefits

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

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Combined with medical deductible	Combined with medical deductible
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.*	20% coinsurance after deductible	20% coinsurance after deductible (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.*	20% coinsurance after deductible	20% coinsurance after deductible (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.*	20% coinsurance after deductible	20% coinsurance after deductible (retail). No coverage (home delivery).

Your summary of benefits

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.

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:

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) 630-6742。

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.

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) 630-6742.

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.

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) 630-6742.

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。

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (833) 630-6742 로 문의하십시오.

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.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (833) 630-6742 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) 630-6742.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (833) 630-6742.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (833) 630-6742.

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.

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.