



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at <https://eoc.anthem.com/eocdps/aso> or by calling 1-800-445-7490.

| Important Questions | Answers | Why this Matters: |
|---|---|--|
| What is the overall <u>deductible</u> ? | In-network: \$500/Individual; \$1,000/Family Out-of-network: \$500/Individual; \$1,000/Family Services not subject to deductible are noted in Limitations & Exceptions. | You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible . |
| Are there other <u>deductibles</u> for specific services? | No. | You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| Is there an <u>out-of-pocket limit</u> on my expenses? | Yes. In-network providers: \$2,000 Individual /\$4,000 Family Out-of-network providers: \$2,000 Individual /\$4,000 Family For prescription drugs: \$3000 Individual / \$6000 Family | The out-of-pocket limit is the most you could pay during a coverage period (one calendar year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| What is not included in the <u>out-of-pocket limit</u> ? | Costs associated with prescription drug copayments, the cost of care when the benefit limits have been reached, the cost of non-covered services and amounts above the allowed amount for services. | Even though you pay these expenses, they don't count toward the out-of-pocket limit . |
| Is there an overall annual limit on what the plan pays? | No. | The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits. |

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| | | |
|---|---|--|
| <p>Does this plan use a network of providers?</p> | <p>Yes. For a list of participating medical providers, see www.anthem.com or call 1-800-445-7490.</p> | <p>If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.</p> |
| <p>Do I need a referral to see a specialist?</p> | <p>No.</p> | <p>You can see a specialist you choose for covered services without permission from this plan.</p> |
| <p>Are there services this plan doesn't cover?</p> | <p>Yes.</p> | <p>Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about excluded services.</p> |



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use PPO **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use Network Providers | Your Cost If You Use Non-Network Providers | Limitations & Exceptions |
|--|---|--|--|--|
| <p>If you visit a health care provider's office or clinic</p> | <p>Primary care visit to treat an injury or illness</p> | <p>\$15 copay/visit</p> | <p>40% coinsurance</p> | <p>Deductible does not apply to in-network care.</p> |
| | <p>Specialist visit</p> | <p>\$15 copay/visit</p> | <p>40% coinsurance</p> | <p>Deductible does not apply to in-network care.</p> |

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Virginia United Methodist Conference: KeyCare 500

Coverage Period: 01/01/2016 – 12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | Plan Type: PPO

| Common Medical Event | Services You May Need | Your Cost If You Use Network Providers | Your Cost If You Use Non-Network Providers | Limitations & Exceptions |
|----------------------|--|--|--|---|
| | Other practitioner office visit | \$15 PCP/specialist /copay/visit / 20% coinsurance/ chiropractor | 40% coinsurance | Deductible does not apply to office visits requiring copay. Spinal manipulation/manual medical interventions limited to 30 visits per member per calendar year combined in- and out-of-network. |
| | Preventive care/screening/immunization | No charge | 40% coinsurance | Deductible does not apply to in-network care. |
| If you have a test | Diagnostic test (x-ray, blood work) | 20% coinsurance | 40% coinsurance | —————none————— |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | Pre-authorization required. |

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| Common Medical Event | Services You May Need | Your Cost If You Use Network Providers | Your Cost If You Use Non-Network Providers | Limitations & Exceptions |
|---|--|--|---|--|
| <p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at www.anthem.com</p> | Tier 1 | \$15 copay/ prescription for Retail \$30 copay / prescription for Mail order | \$15 copay/ prescription for Retail \$30 copay / prescription for Mail order* | <p>Retail pharmacy drugs are limited to a 30-day supply. Mail order drugs are limited to a 90-day day supply.</p> <p>If you visit an out-of-network pharmacy, you will pay the full cost of your prescription at the pharmacy then file a claim for reimbursement. Reimbursement will be based on what a participating pharmacy would receive had the prescription been filled at a participating pharmacy. *You may also be subject to any costs above the allowed amount.</p> |
| | Tier 2 | \$30 copay/ prescription for Retail \$60 copay / prescription for Mail order | \$30 copay/ prescription for Retail \$60 copay / prescription for Mail order* | <p>Your plan uses a preferred drug list (formulary) which identifies the status of covered drugs. Some drugs may require preauthorization, while other drugs are subject to step therapy and quantity limit requirements. If the necessary preauthorization is not obtained, the drug may not be covered.</p> |
| | Tier 3 | \$50 copay/ prescription for Retail \$100 copay / prescription for Mail order | \$50 copay/ prescription for Retail \$100 copay / prescription for Mail order* | <p>Out of pocket: \$3000 Individual / \$6000 Family</p> |
| <p>If you have outpatient surgery</p> | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | —————none————— |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | —————none————— |

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Coverage Period: 01/01/2016 – 12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | Plan Type: PPO

| Common Medical Event | Services You May Need | Your Cost If You Use Network Providers | Your Cost If You Use Non-Network Providers | Limitations & Exceptions |
|---|------------------------------------|--|--|--|
| If you need immediate medical attention | Emergency room services | 20% coinsurance | 40% coinsurance | Visits to an out-of-network emergency room for emergency services will be covered at in-network benefit levels. The out-of-network benefit shown reflects the cost shares for visits to an out-of-network emergency room for services that are not for emergency Services. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | —————none————— |
| | Urgent care | \$15 copay/visit | 40% Coinsurance | Deductible does not apply to in-network care. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | Pre-certification required. |
| | Physician/surgeon fee | 20% coinsurance | 40% coinsurance | —————none————— |

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Virginia United Methodist Conference: KeyCare 500

Coverage Period: 01/01/2016 – 12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | Plan Type: PPO

| Common Medical Event | Services You May Need | Your Cost If You Use Network Providers | Your Cost If You Use Non-Network Providers | Limitations & Exceptions |
|---|--|--|--|--|
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | No charge /office-based treatment / 20% coinsurance /facility based services | 40% coinsurance | Deductible does not apply to in-network office-based services. |
| | Mental/Behavioral health inpatient services | 20% coinsurance | 40% coinsurance | Pre-certification required. |
| | Substance use disorder outpatient services | No charge /office-based treatment / 20% coinsurance /facility based services | 40% coinsurance | Deductible does not apply to in-network office-based services |
| | Substance use disorder inpatient services | 20% coinsurance | 40% coinsurance | Pre-certification required. |
| If you are pregnant | Pre-natal and post-natal care | \$15 copay/once/visit / 20% coinsurance for pre- & postnatal care and delivery (global bill) | 40% coinsurance | One time copay for in-network initial visit to confirm pregnancy. Deductible does not apply to this visit. |
| | Delivery and all inpatient services | 20% coinsurance | 40% coinsurance | —————none————— |
| If you need help recovering or have other special health needs | Home health care | 20% coinsurance | Not covered. | 100 visit limit per member per calendar year in- and out-of-network. |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance | —————none————— |
| | Habilitation services | 20% coinsurance | 40% coinsurance | —————none————— |
| | Skilled nursing care | 20% coinsurance | Not covered. | 100 day per stay limit; pre-authorization required. |
| | Durable medical equipment | 20% coinsurance | 20% coinsurance | —————none————— |
| | Hospice service | No Charge | 40% coinsurance | Deductible does not apply to in-network care. |
| If your child needs | Eye exam | Not covered | Not covered | —————none————— |

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| Common Medical Event | Services You May Need | Your Cost If You Use Network Providers | Your Cost If You Use Non-Network Providers | Limitations & Exceptions |
|----------------------|-----------------------|--|--|--------------------------|
| dental or eye care | Glasses | Not covered | Not covered | —————none————— |
| | Dental check-up | Not covered | Not covered | —————none————— |

Excluded Services & Other Covered Services:

| Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.) | | |
|--|--|---|
| <ul style="list-style-type: none"> Acupuncture Cosmetic surgery Dental care Morbid obesity | <ul style="list-style-type: none"> Hearing aids Long-term care | <ul style="list-style-type: none"> Non-emergency care when traveling outside the U.S. Routine foot care |

| Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.) | |
|---|--|
| <ul style="list-style-type: none"> Chiropractic care Home private duty nursing | <ul style="list-style-type: none"> Autism Spectrum Disorder |

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Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 540-586-1803. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

Anthem Blue Cross and Blue Shield: Appeals, Attention Member Services, P.O. Box 27401, Richmond, VA 23279.

Express Scripts, Inc.: Attention: Pharmacy Appeals, Mail Route BL0390, 6625 West 78th Street, Bloomington, MN 55439.

You may also contact the Department of Labor’s Employee Benefits Security Administration at 1-866-EBSA (3272) or www.dol/ebsa/healthreform.

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Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoolwoł únízinigo t'áá diné k'éjúgo, t'áá shoodí ba na'alnǐhí ya sidáhí bich'í naabídííłkiid. Eí doo biigha daago ni ba'nija'go ho'aalagú bich'í hodiilní. Hai'daq iini'taago eíya, t'áá shoodí diné ya atáh halne'ígú ní béesh bee hane'í wólta' bi'ki si'niilígú bi'kéhgo bich'í hodiilní.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,520
- Patient pays \$2,020

Sample care costs:

| | |
|----------------------------|----------------|
| Hospital charges (mother) | \$2,700 |
| Routine obstetric care | \$2,100 |
| Hospital charges (baby) | \$900 |
| Anesthesia | \$900 |
| Laboratory tests | \$500 |
| Prescriptions | \$200 |
| Radiology | \$200 |
| Vaccines, other preventive | \$40 |
| Total | \$7,540 |

Patient pays:

| | |
|----------------------|----------------|
| Deductibles | \$500 |
| Copays | \$20 |
| Coinsurance | \$1,350 |
| Limits or exclusions | \$150 |
| Total | \$2,020 |

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3,790
- Patient pays \$1,610

Sample care costs:

| | |
|--------------------------------|----------------|
| Prescriptions | \$2,900 |
| Medical Equipment and Supplies | \$1,300 |
| Office Visits and Procedures | \$700 |
| Education | \$300 |
| Laboratory tests | \$100 |
| Vaccines, other preventive | \$100 |
| Total | \$5,400 |

Patient pays:

| | |
|----------------------|----------------|
| Deductibles | \$500 |
| Copays | \$1,000 |
| Coinsurance | \$30 |
| Limits or exclusions | \$80 |
| Total | \$1,610 |

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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