Your summary of benefits

Anthem®

Anthem® Blue Cross and Blue Shield

Your Plan: Stafford County Public Schools: KeyCare Premium Plan

Your Network: KeyCare

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$200 person / $400 family	$1,000 person / $2,000 family
Out-of-Pocket Limit	$3,000 person / $6,000 family	$6,250 person / $12,500 family
The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per person out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the per person deductible or per person out-of-pocket maximum. Your copays, coinsurance and deductible count toward your out of pocket amount(s). In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other.		
Preventive Care / Screening / Immunization	No charge	50% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	50% coinsurance after medical deductible is met
Virtual Care (Telemedicine / Telehealth Visits)		
Virtual Visits - Online visits with Doctors who also provide services in person		
Primary Care (PCP)	$20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Mental Health and Substance Abuse care	$20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Specialist	$40 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Medical Chats and Virtual (Video) Visits for Primary Care from our Online Provider K Health, through its affiliated Provider groups	No charge	
Virtual Visits from Online Provider LiveHealth Online *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*		
Primary Care (PCP) and Mental Health and Substance Abuse	$0 copay per visit medical deductible does not apply	
Specialist Care	$40 copay per visit medical deductible does not apply	
Visits in an Office		
Primary Care (PCP)	$20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Specialist Care	$40 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal) *Dependent maternity is not covered.*	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Retail Health Clinic	$20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Manipulation Therapy *Coverage is limited to 30 visits per benefit period.*	$25 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Acupuncture	$20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Other Services in an Office		
Allergy Testing	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Chemo/Radiation Therapy	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Dialysis/Hemodialysis	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Prescription Drugs *Dispensed in the office*	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Surgery	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Diagnostic Services **Lab**		
Office	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Preferred Reference Lab	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
X-Ray		
Office	$30 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Outpatient Hospital	$30 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	$150 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	$150 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Emergency and Urgent Care		
Urgent Care	$20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Emergency Room Facility Services	20% coinsurance after medical deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after medical deductible is met	Covered as In-Network
Ambulance *Non-emergency, Non-network ambulance limited to a $50,000 maximum payment per trip. Does not apply to air ambulance.*	20% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse		
Doctor Office Visit	$20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Facility Visit		
Facility Fees	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Doctor Services	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Freestanding Surgical Center	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Doctor and Other Services		
Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	$400 copay per admission and 20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Doctor and other services	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 100 visits per benefit period.*	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Rehabilitation services *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period.*		
Office	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Cardiac rehabilitation *Unlimited visits per benefit period.*		
Office	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Skilled Nursing Care (facility) *Coverage is limited to 100 days per admission.*	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Inpatient Hospice	No charge	50% coinsurance after medical deductible is met
Durable Medical Equipment	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with Non-Network medical deductible
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Prescription Drug Coverage *Cost shares for drugs included on the National drug list appear below. Your plan uses the Base Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.*		
Home Delivery Pharmacy *Maintenance medication are available through CarelonRx Home Delivery Pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.*		
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$10 copay per prescription (30 day supply retail), $30 copay per prescription (90 day supply retail) and $20 copay per prescription (home delivery) Deductible does not apply	$10 copay per prescription (30 day supply retail), $30 copay per prescription (90 day supply retail) and Not covered (home delivery) Deductible does not apply

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$30 copay per prescription (30 day supply retail), $90 copay per prescription (90 day supply retail) and $60 copay per prescription (home delivery) Deductible does not apply	$30 copay per prescription (30 day supply retail), $90 copay per prescription (90 day supply retail) and Not covered (home delivery) Deductible does not apply
Tier 3 - Typically Non-Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$50 copay per prescription (30 day supply retail), $150 copay per prescription (90 day supply retail) and $100 copay per prescription (home delivery) Deductible does not apply	$50 copay per prescription (30 day supply retail), $150 copay per prescription (90 day supply retail) and Not covered (home delivery) Deductible does not apply
Tier 4 - Typically Specialty (brand and generic) *Per 30 day and 90 day supply (specialty pharmacy).*	$150 copay per prescription, (30 day supply retail) and $300 copay per prescription, (90 day supply specialty pharmacy) Deductible does not apply	Not covered (retail and home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.		
Children's Vision (up to age 19) **Child Vision Deductible**	$0 person	$0 person
Vision exam	$15 copay per visit	Reimbursed Up to $30
Adult Vision (age 19 and older) **Adult Vision Deductible**	$0 person	$0 person

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Vision exam *Limited to 1 exam per benefit period*	$15 copay per visit	Reimbursed Up to $30

Notes:

- The representations of benefits in this document are subject to Division of Insurance approval and are subject to change.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.

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.

This benefit summary is not to be distributed without also providing access on limitations and exclusions that apply to our medical plans. Visit https://www.anthemplancomparison.com/va to access this information.

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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) 798-0218

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(TTY/TDD: 711)

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