

# Pittsylvania County and Schools: KeyCare 30

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

Coverage Period: 10/01/2016 – 09/30/2017

Coverage for: Individual/Family | Plan Type: PPO



**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 1-800-451-1527.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	In-network: <b>\$1,000</b> /Individual; <b>\$2,000</b> /Family Out-of-network: <b>\$1,500</b> /Individual; <b>\$3,000</b> /Family	You must pay all the costs up to the <u>deductible</u> 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 <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> 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. When using in-network providers: <b>\$6,000</b> Individual / <b>\$12,000</b> Family; when using out-of-network providers: <b>\$11,000</b> Individual / <b>\$22,000</b> Family	The <u>out-of-pocket limit</u> 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 routine vision care, 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 <u>out-of-pocket limit</u> .
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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Does this plan use a <b>network of providers</b> ?	Yes. For a list of participating medical providers, see <a href="http://www.anthem.com">www.anthem.com</a> or call 1-800-451-1527.	If you use an in-network doctor or other health care <b>provider</b> , 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 <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
Do I need a referral to see a <b>specialist</b> ?	No.	You can see a <b>specialist</b> you choose for covered services without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about <b>excluded services</b> .



- **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
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	\$30 copay/visit	40% Coinsurance	Deductible does not apply to in-network care.
	Specialist visit	\$30 copay/visit	40% Coinsurance	Deductible does not apply to in-network care.

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	Other practitioner office visit	\$30 copay/visit	40% Coinsurance	Deductible does not apply to in-network care. Spinal manipulation /manual medical therapy has \$25 office visit copay and is limited to 30 visits per member per calendar year combined in- and out-of-network services.
	Preventive care/screening/immunization	No charge	40% Coinsurance	—————none—————
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	Preauthorization required.
<b>If you need drugs to treat your illness or condition</b>  More information about <b>prescription drug coverage</b> is available at <a href="http://www.anthem.com">www.anthem.com</a>	Tier 1	\$10 copay/ prescription for Retail \$20 copay / prescription for Mail order	\$10 copay/ prescription for Retail \$20 copay / prescription for Mail order*	Retail pharmacy drugs are limited to a 30-day or 90- day supply. You pay additional copays for retail fills that exceed 30 days.  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. <b>You may also be subject to any costs above the allowed amount.*</b>
	Tier 2	\$40 copay/ prescription for Retail \$80 copay /prescription for Mail order	\$40 copay/ prescription for Retail \$80 copay / prescription for Mail order*	
	Tier 3	\$60 copay / Retail \$120 prescription / Mail order	\$60 copay / Retail \$120 prescription / Mail order*	

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	Tier 4	20% coinsurance / limited to \$400 per prescription for Mail order**	n/a**	Your plan uses a preferred drug list of covered drugs. Some drugs may require preauthorization, while other drugs are subject to step therapy and quantity limit requirements. If the necessary pre-authorization is not obtained, the drug may not be covered.  **Specialty medications must be purchased through Accredo Specialty Pharmacy. Specialty medications are limited to a 30 day fill with the exception of HIV/AIDS and transplant medications.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	40% Coinsurance	—————none—————
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	—————none—————
<b>If you need immediate medical attention</b>	Emergency room services	20% Coinsurance	40% Coinsurance	—————none—————
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	—————none—————
	Urgent care	\$30 copay/visit	40% Coinsurance	Deductible does not apply to in-network care.
<b>If you have a hospital stay</b>	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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<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$30 copay per office visit/20% Coinsurance for outpatient facility based services	40% Coinsurance	Deductible does not apply to office visits with in-network providers.
	Mental/Behavioral health inpatient services	20% Coinsurance	40% Coinsurance	Pre-certification required.
	Substance use disorder outpatient services	\$30 copay per office visit/20% Coinsurance for outpatient facility based services	40% Coinsurance	Deductible does not apply to office visits with in-network providers.
	Substance use disorder inpatient services	20% Coinsurance	40% Coinsurance	Pre-certification required.
<b>If you are pregnant</b>	Prenatal and postnatal care	\$30 copay/once; 20% coinsurance for global bill covering pre- and post-natal care and delivery	40% Coinsurance	One time copay for initial visit to confirm pregnancy. Deductible does not apply to this visit.
	Delivery and all inpatient services	20% Coinsurance	40% Coinsurance	—————none—————

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<b>If you need help recovering or have other special health needs</b>	Home health care	20% Coinsurance	40% Coinsurance	100 visit limit per calendar year.
	Rehabilitation services	20% Coinsurance	40% Coinsurance	30 visit limit combined for physical and occupational therapy per member per calendar year combined in- and out-of-network; 30 visit limit per member per calendar year for speech therapy combined in- and out-of-network.
	Habilitation services	20% Coinsurance	40% Coinsurance	—————none—————
	Skilled nursing care	20% Coinsurance	40% Coinsurance	100 day per stay limit; pre-authorization required.
	Durable medical equipment	20% Coinsurance	40% Coinsurance	—————none—————
	Hospice service	No charge	40% Coinsurance	—————none—————
<b>If your child needs dental or eye care</b>	Eye exam	\$15 copay/ visit	\$30 allowance/visit	One eye exam per member per calendar year.
	Glasses	Not covered	Not covered	—————none—————
	Dental check-up	Not covered	Not covered	—————none—————

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### 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.)

- Acupuncture
- Cosmetic surgery
- Dental care
- Morbid obesity
- Hearing aids
- Infertility treatment
- Long-term care
- 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.)

- Chiropractic care
- Home private duty nursing
- Autism Spectrum Disorder

### 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.

This policy has exclusions, limitations, reduction of benefits and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, call your insurance agent or Anthem.

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](http://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](http://www.cciio.cms.gov).

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### 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 78<sup>th</sup> 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](http://www.dol/ebsa/healthreform).

### 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 adoolwol íinízinigo t'áá diné k'éjígoo, t'áá shoodí ba na'alníhí ya sidáhí bich'í naabídíilkiid. Eí doo biigha daago ni ba'nija'go ho'aalagú bich'í hodiilní. Hai'daa iini'taago eíya, t'áá shoodí diné ya atáh halne'ígú ní béesh bee hane'í wólta' bí'ki si'niilígú bí'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 \$5,120
- Patient pays \$2,420

#### 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
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$1,000
Copays	\$20
Coinsurance	\$1,250
Limits or exclusions	\$150
<b>Total</b>	<b>\$2,420</b>

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

- Amount owed to providers: \$5,400
- Plan pays \$3,530
- Patient pays \$1,870

#### 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
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$1,000
Copays	\$570
Coinsurance	\$220
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,870</b>

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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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