Anthem

Anthem KeyCare 25/650 City of Lynchburg & Lynchburg City Schools 1/1/17-12/31/17

In-Network Services	You Pay
Preventive Care Services	
Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits. * During the course of a routine screening procedure, abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and *your* provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by *your* provider, which will result in a member cost share.	No cost share*
Doctor Visits	
o office visits o urgent care visits o pre- and postnatal office visits* o home visits *Office Visit Lab services and pathology performed by the same provider on the same day will be covered at 100% after the office visit copay.* **If your physician submits one bill for prenatal, delivery, and postnatal care, services are covered as maternity delivery services. (See Inpatient stay section.)*	$25 for each visit to a PCP $37.50 for each visit to a specialist
o allergy injections o allergy serum	$5 for each visit
o mental health and substance abuse visits	$25 for each visit
o physical therapy visits in an office setting (30 visit limit)* o occupational therapy visits in an office setting (30 visit limit)* o speech therapy visits in an office setting (30 visit limit)* **Limit does not apply to Autism Spectrum Disorder.*	$37.50 for each visit
o spinal manipulations and other manual medical intervention visit (20 visit limit)	$37.50 for each visit
o emergency room	$65 for each visit
All Other In-Network Services	**You Pay**
You will pay all the costs associated with care until you have paid $650 in one calendar or plan year. This is known as your deductible. o If two people are covered under your plan, each of you will pay the first $650 of the cost of your care ($1,300 total). o If three or more people are covered under your plan, together you will pay the first $1,300 of the cost of your care. However, the most one family member will pay is $650. Once you reach your deductible you pay:	
Autism Spectrum Disorder (ASD) – For children from age 2 through 10	
o diagnosis and treatment of autism spectrum disorder including: o behavioral health treatment* o psychiatric care o therapeutic care** o pharmacy care o psychological care * *Mental Health Services* ***Unlimited physical, occupational and speech therapy.*	Member cost shares will be dependent on the services rendered.
o applied behavioral analysis o unlimited per member annual maximum	20% of the amount the health care professionals in our network have agreed to accept for their services
Early Intervention – For children from birth up to age 3	
o unlimited per member per calendar year up to age 3	Member cost shares will be dependent on the services rendered.
Other Outpatient Services	
o shots and therapeutic injections including infusion medications o dialysis o diagnostic lab services* o chemotherapy (not given orally), IV, radiation, cardiac and respiratory therapy o medical appliances, supplies and medications, o durable medical equipment o in–office surgery o diagnostic x-rays o ambulance travel * *Office Visit Lab services and pathology performed by the same provider on the same day will be covered at 100% after the office visit copay.*	20% of the amount the health care professionals in our network have agreed to accept for their services

Your benefit period runs on a calendar year basis. A calendar year means your benefit period runs from January through December.

For benefits listed with specific limits all services received in the calendar year for that benefit are applied to that limit (whether received in or out-of- network).

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In-Network Services	You Pay
Other Outpatient Services - Continued	
o diabetic supplies, equipment and education	Member cost shares will be dependent on the services rendered.
Outpatient Visits in a Hospital or Facility	
o physical therapy (30 visit limit)* o occupational therapy (30 visit limit)* o speech therapy (30 visit limit)* o partial day mental health and substance use services o surgery **Limit does not apply to Autism Spectrum Disorder.*	20% of the amount the health care professionals in our network have agreed to accept for their services
Care at Home	
o home health care (100 visit limit) o private duty nursing limited to 16 hours per member per calendar year* **Since there is no network for this service, you may be billed for the difference between what we pay for this service and the amount the private duty nursing service charged.*	20% of the amount the health care professionals in our network have agreed to accept for their services
o hospice care	No cost share
Inpatient Stays in a Network Hospital or Facility	
o semi-private room, intensive care or similar unit o physician, nursing and other medically necessary professional services in the hospital including anesthesia, surgical and maternity delivery services. o skilled nursing facility care (30 day limit per admission)	20% of the amount the health care professionals in our network have agreed to accept for their services

Out-of-Network Services

Using Doctors, Hospitals and Other Health Care Professionals not Contracted to Provide Benefits

It's important to remember that health care professionals not in our network can charge whatever they want for their services. If what they charge is more than the fee our network health care professionals have agreed to accept for the same service, they may bill you for the difference between the two amounts. You will pay all the costs associated with the covered services outlined in this insert until you have paid $780 in one calendar or plan year. This is called your out-of-network deductible.

- If two people are covered under your plan, each of you will pay the first $780 of the cost of your care ($1,480 total).
- If three or more people are covered under your plan, together you will pay the first $1,480 of the cost of your care. However, the most one family member will pay is $780.

Once you have reached this amount, when you receive covered services we will pay 60% of the fee our network health care professionals have agreed to accept for the same service. You will pay the rest, including any difference between the fee our network health care professionals have agreed to accept for the same service and the amount the health care professional not in our network charges.

Out-of-Pocket Maximums

What You Will Pay for Covered Services in One Calendar Year

When using network professionals

If you are the only one covered by your plan, you will pay $2,600 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is $0, except for those services listed below that do not count toward the annual out-of-pocket maximum.*

- If two people are covered under your plan, each of you will pay $2,600 ($5,200 total).
- If three or more people are covered under your plan, together you will pay $5,200. However, no family member will pay more than $2,600 toward the limit.

When not using network professionals

If you are the only one covered by your plan, you will pay $5,200 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is $0, except for those services listed below that do not count toward the annual out-of-pocket maximum.*

- If two people are covered under your plan, each of you will pay $5,200 ($10,400 total).
- If three or more people are covered under your plan, together you will pay $10,400. However, no family member will pay more than $5,200 toward the limit.

***The following do not count toward the calendar year out-of-pocket maximum:**

- your share of the cost of outpatient prescription drugs
- the cost of care received when the benefit limits have been reached
- the cost of services and supplies not covered under your benefits
- the additional amount health care professionals not in our network may bill you when their charge is more than what we pay

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 summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Your prescription drug plan

Anthem National 4 Tier drug formulary

Your Smart 90 Prescription Drug Plan	Tier 1 Copay	Tier 2 Copay	Tier 3 Copay	Tier 4 Copay (Specialty Drugs)
Up to a 30-day medication supply at participating pharmacies	40% coinsurance, $20 minimum, $100 maximum/script	40% coinsurance, $20 minimum, $100 maximum/script	40% coinsurance, $20 minimum, $100 maximum/script	40% coinsurance, $20 minimum, $100 maximum/script
Up to a 90-day medication supply delivered to your home	40% coinsurance, $60 minimum, $300 maximum/script	40% coinsurance, $60 minimum, $300 maximum/script	40% coinsurance, $60 minimum, $300 maximum/script	*40% coinsurance, $60 minimum, $300 maximum/script. 90 day mail order benefit only allowed for Transplant & HIV/AIDS drugs.
Up to a 90-day maintenance medication supply purchased at a Smart90 participating** retail pharmacy	40% coinsurance, $60 minimum, $300 maximum/script	40% coinsurance, $60 minimum, $300 maximum/script	40% coinsurance, $60 minimum, $300 maximum/script	Not Applicable
**Most specialty medications are limited to up a 30 day supply regardless of whether they are retail or mail.*				

If you get the brand name drug when a generic drug is available, you will pay the applicable coinsurance based on the brand drug cost plus the difference in cost between the brand and the generic.

Prescription Drug Out of Pocket Maximum: $4,500 Individual/$9,000 Family (separate from the Medical out of pocket maximum)

Mandatory Mail Order: Maintenance classified medications must be filled through the Mail Order Pharmacy or Smart 90 participating pharmacies after a specified number of 30 day retail fills.

30-Day Retail Pharmacy Network

Our network includes more than 69,000 pharmacies across the country. That means you have easy access to your prescriptions wherever you are – at work, home or even on vacation. Using pharmacies in the network will help you get the most from your drug plan. When picking up your prescription at the pharmacy, be sure to show your plan ID card.

Smart 90 Pharmacies

Smart 90** is a unique network that offers more ways for you to get the maintenance medications you need. Maintenance medications are drugs taken on an ongoing basis for conditions such as asthma, diabetes or high cholesterol. Through Smart 90, you can choose to get a 90-day supply of medications from a participating retail pharmacy or the mail order pharmacy.

**Only certain pharmacies in our network participate in the Smart 90 program. Be sure to check with your local pharmacy to verify their participation status prior to placing your 90 day retail prescription order.

To make sure your pharmacy's in our network, visit anthem.com and select Find a Doctor which will take you to the list of providers, pharmacies and hospitals who participate in our network.

Your prescription drug plan (continued)

Home Delivery Pharmacy

Members needing maintenance medications also have the option to use our Home Delivery Pharmacy service. Our preferred Home Delivery Pharmacy, managed by Express Scripts, sends you the medicine you need, right to your door. As a home delivery customer, you'll also enjoy:

- 90-day maintenance medications for less cost than if you purchased them at a retail location
- Free standard shipping
- Access to pharmacists for drug questions
- Safe, accurate prescriptions

Ordering refills

With home delivery, you don't have to worry about running out of medication. That's because the pharmacy will let you know when it's time to order refills. You can easily order by phone, mail or online.

Specialty Pharmacy

Accredo, the Express Scripts specialty pharmacy, provides support and medicine for people with complex, long-term conditions. Most specialty medications are limited up to a 30 day supply regardless of whether they are retail or mail (Transplant and HIV/AIDS medications are covered up to a 90 day supply). They include (but are not limited to):

- Asthma
- Bleeding Disorders
- Cancer
- Cystic Fibrosis
- Crohn's Disease
- Growth Hormone
- Hepatitis
- HIV/AIDS
- Iron Overload
- Multiple sclerosis
- Psoriasis
- Pulmonary arterial hypertension
- Rheumatoid arthritis
- Respiratory syncytial virus (RSV)
- Transplant

Accredo CareLogic© programs help people with the conditions listed on this page. These programs teach you about treatment for your condition and help you understand and cope with medication and side effects. CareLogic nurses and pharmacists will schedule time with you to find out how you are doing. Nurses, pharmacists and patient care advocates work together to help improve your care. Their goal is to help you get the best results from your treatments. Call 800-870-6419 to learn about how CareLogic can help you better manage your health condition.

Drug list

Our drug list (sometimes called a formulary) is a list of prescription drugs covered by your plan. It's made up of hundreds of brand and generic drugs. We research drugs and select ones that are safe, work well and offer the best value. That's because we think it's important to cover drugs that help people stay healthy so they can work, go to school, and continue the activities of a busy life.

Sometimes we update the Drug List if new drugs come to market, or if new research becomes available. To view the current list, visit anthem.com. Click on "Customer Care" in the top-right corner. Select your state, and then click "Download Forms. "You'll find the Drug List on this page. If you don't have access to a computer, you can check the status of a drug by calling Customer Service at the phone number on your plan ID card.

Preferred Generics

If you're taking a brand name drug, you could save money by switching to an effective, lower cost generic drug. Your plan covers both brand and generic (or non-brand) drugs. When you choose a generic, you'll get the effectiveness of a brand drug – but usually at a lower cost.

Your prescription drug plan (continued)

Prescription drugs will always be dispensed as ordered by your physician. If you or your doctor requests a brand name drug when a generic is available, you will pay your usual copayment for the generic drug plus the difference in the allowable charge between the generic and brand name drug.

Prior authorization

Most prescriptions are filled right away when you take them to the pharmacy. But, some drugs need our review and approval before they're covered. This process is called prior authorization. It focuses on drugs that may have:

- Risk of serious side effects
- High potential for incorrect use or abuse
- Better options that may cost you less

If your drug needs approval, your pharmacist will let you know. To check in advance, call the Customer Service phone number on your ID plan card.

Step Therapy

Step Therapy may be required for certain drugs. Step Therapy refers to the process in which you may be required to use one type of medication before benefits are available for another. Step Therapy helps you and your doctor chose drugs that are safe, affordable and right for you. When your doctor prescribes a drug that requires step therapy, a message is sent to your pharmacy. This lets the pharmacist know you must first try a different, similar drug that's covered by your plan. The pharmacist will call your doctor to get a prescription for the new drug.

Quantity Limit

Taking too much medicine or using it too often isn't safe. And it may even drive up your health care costs. That's why your plan may limit the amount of medicine that's covered for a certain length of time. For example, a drug may have a limit of 30 pills per 30 days. If you refill a prescription too soon or your doctor prescribes an amount that's higher than usual, your pharmacist will tell you.

The Drug List also includes this information. To view it, visit anthem.com. Click on "Customer Care" in the top-right corner. Select your state, and then click on "Download Forms." You'll find the Drug List on this page.

Anthem Blue Cross and its affiliate, HealthKeepers, Inc., receives financial credits from drug manufacturers based on total volume of the claims processed for their product utilized by Anthem Blue Cross and Blue Shield and Anthem HealthKeepers members. These credits are retained by Anthem Blue Cross and Blue Shield and HealthKeepers, Inc. as a part of its fee for administering the program for self-funded groups and used to help stabilize rates for fully-insured groups. Reimbursements to pharmacies are not affected by these credits.

Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. Anthem Blue Cross and Blue Shield and its affiliates, HealthKeepers, Inc., are independent licensees of the Blue Cross and Blue Shield Association.®ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

This benefits overview insert is only one piece of your entire enrollment package. See the enrollment brochure for a list of your plan's exclusions and limitations and applicable policy form numbers.

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