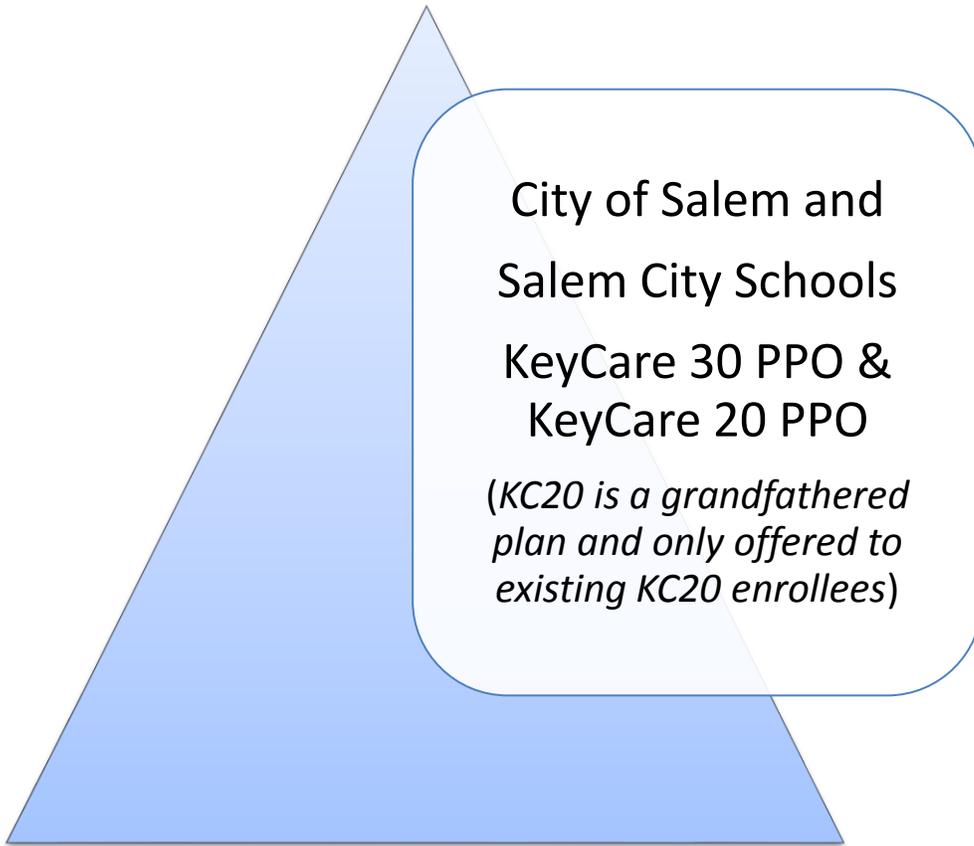


Summary of Benefits



Effective October 1, 2017

Anthem KeyCare 30 PPO Plan: \$2,000 In-Network Deductible

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 <i>your</i> 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 <i>your</i> provider, which will result in a member cost share.	No cost share
Routine Vision	
<ul style="list-style-type: none"> annual routine eye exam <i>Plus valuable discounts on eyewear</i>	\$15 for each visit
Doctor Visits	
<ul style="list-style-type: none"> office visits urgent care visits online visits (https://livehealthonline.com) (does not include livehealthonline mental health/substance abuse therapist visits) mental health and substance abuse office visit (including livehealthonline therapist visits) spinal manipulation and other manual medical intervention visits (30 visit limit) 	<ul style="list-style-type: none"> pre- and postnatal office visits* home visits \$30 for each visit to a PCP \$50 for each visit to a specialist
All Other In-Network Services	
You will pay all the costs associated with care until you have paid \$2,000 in one calendar or plan year. This is known as your deductible. <ul style="list-style-type: none"> If two people are covered under your plan, each of you will pay the first \$2,000 of the cost of your care (\$4,000 total). If three or more people are covered under your plan, together you will pay the first \$4,000 of the cost of your care. However, the most one family member will pay is \$2,000. Once you reach your deductible you pay:	
Autism Spectrum Disorder (ASD) – For children from age 2 through 10	
<ul style="list-style-type: none"> diagnosis and treatment of autism spectrum disorder including: <ul style="list-style-type: none"> behavioral health treatment* psychiatric care therapeutic care** 	Member cost shares will be dependent on the services rendered.
* Mental Health Services **Unlimited physical, occupational and speech therapy.	
<ul style="list-style-type: none"> applied behavioral analysis 	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	
<ul style="list-style-type: none"> unlimited per member per calendar year up to age 3 	Member cost shares will be dependent on the services rendered.
Other Outpatient Services	
<ul style="list-style-type: none"> shots and therapeutic injections medical appliances, supplies and medications, including infusion medications durable medical equipment diagnostic lab services in-office surgery chemotherapy (not given orally), IV, radiation, cardiac and respiratory therapy 	<ul style="list-style-type: none"> physical and occupational therapy visits in an office setting (30 combined visits)* speech therapy visits in an office setting (30 visit limit)* dialysis diagnostic x-rays ambulance travel
*Limit does not apply to Autism Spectrum Disorder.	

Your benefit period is a calendar year. 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).

In-Network Services	You Pay
Other Outpatient Services - Continued	
<ul style="list-style-type: none"> ○ diabetic supplies, equipment and education 	Member cost shares will be dependent on the services rendered.
Outpatient Services in a Hospital or Facility	
<ul style="list-style-type: none"> ○ physical therapy and occupational therapy (30 combined visits)* ○ speech therapy (30 visit limit)* ○ partial day mental health and substance abuse services ○ emergency room ○ surgery <p><i>*Limit does not apply to Autism Spectrum Disorder.</i></p>	20% of the amount the health care professionals in our network have agreed to accept for their services
Care at Home	
<ul style="list-style-type: none"> ○ home health care (100 visits) ○ private duty nursing limited to 16 hours per member per calendar year <p><i>*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.</i></p>	20% of the amount the health care professionals in our network have agreed to accept for their services
<ul style="list-style-type: none"> ○ hospice care 	No cost share
Inpatient Stays in a Network Hospital or Facility	
<ul style="list-style-type: none"> ○ semi-private room, intensive care or similar unit ○ physician, nursing and other medically necessary professional services in the hospital including anesthesia, surgical and maternity delivery services. ○ skilled nursing facility care (100 days for each 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	
<p>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 \$3,000 in one calendar year. This is called your out-of-network deductible.</p> <ul style="list-style-type: none"> ○ If two people are covered under your plan, each of you will pay the first \$3,000 of the cost of your care (\$6,000 total). ○ If three or more people are covered under your plan, together you will pay the first \$6,000 of the cost of your care. However, the most one family member will pay is \$3,000. <p>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. If you go to an eye care professional not in our network for your routine eye examination, we will pay \$30 (whether or not you have reached the \$3,000 out-of-network deductible) and you will pay the rest of what the professional charges.</p>	
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 \$5,000 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 \$5,000 (\$10,000 total).
- If three or more people are covered under your plan, together you will pay \$10,000. However, no family member will pay more than \$5,000 toward the limit.

When not using network professionals

If you are the only one covered by your plan, you will pay \$7,250 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 \$7,250 (\$14,500 total).
- If three or more people are covered under your plan, together you will pay \$14,500. However, no family member will pay more than \$7,250 toward the limit.

The in-network calendar year out-of-pocket maximum includes in-network medical copays, deductible, coinsurance, and in-network pharmacy copays & coinsurance.

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

- your share of the cost of routine vision care
- the cost of care received when the benefit limits have been reached
- the cost of services and supplies not covered under your Anthem KeyCare 30 plan
- the additional amount health care professionals not in our network may bill you when their charge is more than what we pay

*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.*

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the federal health care reform laws. Anthem believes the benefits are compliant with applicable law, but they have not been approved by the Virginia Bureau of Insurance at this time. We may be required to make additional changes to this summary of benefits

Anthem KeyCare 20 PPO Plan: \$0 In-Network Deductible *(Grandfathered plan, only available to existing KC20 enrollees)*

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 <i>your</i> 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 <i>your</i> provider, which will result in a member cost share.	*No cost share
Routine Vision	
<ul style="list-style-type: none"> ○ annual routine eye exam <p style="margin-left: 20px;"><i>Plus valuable discounts on eyewear</i></p>	\$15 for each visit
Doctor Visits	
<ul style="list-style-type: none"> <li style="width: 50%;">○ office visits <li style="width: 50%;">○ spinal manipulations and other manual medical intervention visits (30 visit limit) <li style="width: 50%;">○ urgent care visits <li style="width: 50%;">○ in office surgery <li style="width: 50%;">○ home visits 	\$30 for each visit to a PCP \$50 for each visit to a specialist
<ul style="list-style-type: none"> ○ online visits (www.livehealthonline.com) (doesn't include livehealthonline mental health/substance abuse therapist visit) 	\$20 for each visit
Autism Spectrum Disorder (ASD) – For children from age 2 through 10	
<ul style="list-style-type: none"> ○ diagnosis and treatment of autism spectrum disorder including: <ul style="list-style-type: none"> <li style="width: 50%;">○ behavioral health treatment* <li style="width: 50%;">○ pharmacy care <li style="width: 50%;">○ psychiatric care <li style="width: 50%;">○ psychological care <li style="width: 50%;">○ therapeutic care** <p>* Mental Health Services **Unlimited physical, occupational and speech therapy.</p>	Member cost shares will be dependent on the services rendered.
<ul style="list-style-type: none"> ○ applied behavioral analysis 	20% of the amount the health care professionals in our network have agreed to accept for their services
Early Intervention – For children from birth through age 2	
<ul style="list-style-type: none"> ○ unlimited per member per calendar year up to age 3 	Member cost shares will be dependent on the services rendered.
Labs, Diagnostic X-rays and Other Outpatient Services	
<ul style="list-style-type: none"> ○ diagnostic lab services ○ diagnostic x-rays ○ dialysis ○ infusion services ○ shots and therapeutic injections, including infusion medications ○ chemotherapy (not given orally), radiation, cardiac and respiratory therapy 	20% of the amount the health care professionals in our network have agreed to accept for their services
<ul style="list-style-type: none"> ○ diabetic supplies, equipment and education 	Member cost shares will be dependent on the services rendered.
<ul style="list-style-type: none"> ○ durable medical equipment 	20% of the amount the health care professionals in our network have agreed to accept for their services.
<ul style="list-style-type: none"> ○ ambulance travel 	\$150 copayment per transport

For the benefits listed with specific limits, all services received during the calendar year from January 1 to December 31 for that benefit are applied to that limit (whether received in or out-of-network).

In-Network Services	You Pay
Outpatient Visits in a Hospital or Facility	
<ul style="list-style-type: none"> ○ physical therapy and occupational therapy (30 combined visits)* ○ speech therapy (30 visit limit)* <p><i>*Limit does not apply to Early Intervention and Autism Spectrum Disorder.</i></p>	<p>PT - \$50 copay plus 20% of the amount the health care professionals in our network have agreed to accept for their services; OT and ST, 20% of the amount the health care professionals in our network have agreed to accept for their services.</p>
<ul style="list-style-type: none"> ○ surgery <p><i>*For the services billed by the doctor, you will pay an additional \$30 or \$50 depending on the type of doctor who treats you.</i></p>	<p>\$200 plus 20% of the amount the health care professionals in our network have agreed to accept for their services*</p>
<ul style="list-style-type: none"> ○ diabetic supplies, equipment and education 	<p>Member cost shares will be dependent on the services rendered.</p>
Emergency Care	
<ul style="list-style-type: none"> ○ emergency room 	<p>\$200 plus 20% of the amount the health care professionals in our network have agreed to accept for their services*</p>
<ul style="list-style-type: none"> ○ emergency room physician services 	<p>20% of the amount the health care professionals in our network have agreed to accept for their services</p>
Mental Health and Substance Abuse Outpatient Services	
<ul style="list-style-type: none"> ○ office visits 	<p>\$30 for each visit</p>
<ul style="list-style-type: none"> ○ outpatient facility (including partial day mental health and substance abuse services) ○ outpatient facility professional provider services 	<p>20% of the amount the health care professionals in our network have agreed to accept for their services</p>
Care at Home	
<ul style="list-style-type: none"> ○ hospice care 	<p>No cost share</p>
<ul style="list-style-type: none"> ○ home health care (100 visits) ○ private duty nursing limited to 16 hours per member per calendar year* <p><i>*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 charges.</i></p>	<p>\$30 copay per visit</p> <p>20% of the amount the health care professionals in our network have agreed to accept for their services.</p>
Maternity	
<ul style="list-style-type: none"> ○ all routine pre- and postnatal care (excluding inpatient stays) 	<p>\$200 per pregnancy</p>
<ul style="list-style-type: none"> ○ diagnostic test ○ non-stress tests and other fetal monitor procedures ○ ultrasounds 	<p>20% of the amount the health care professionals in our network have agreed to accept for their services</p>
Inpatient Stays in a Network Hospital or Facility	
<ul style="list-style-type: none"> ○ semi-private room, intensive care or similar unit <p><i>*You do not have to pay another inpatient copay if you are readmitted for the same or related condition within 90 days of the day you went home.</i></p>	<p>\$300 plus 20% of the amount the health care professionals in our network have agreed to accept for their services*</p>
<ul style="list-style-type: none"> ○ physician, nursing and other medically necessary professional services in the hospital including anesthesia, surgical and maternity delivery services 	<p>20% of the amount the health care professionals in our network have agreed to accept for their services</p>

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 \$400 in one calendar year. This is called your out-of-network deductible.

- If two people are covered under your plan, each of you will pay the first \$500 of the cost of your care (\$1,000 total).
- If three or more people are covered under your plan, together you will pay the first \$1,000 of the cost of your care. However, the most one family member will pay is \$500.

Once you have reached this amount, when you receive covered services we will pay 70% 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. If you go to an eye care professional not in our network for your routine eye examination, we will pay \$30 (whether or not you have reached the \$400 out-of-network deductible) and you will pay the rest of what the professional charges.

Out-of-Pocket Maximums

What You Will Pay for Covered Services in One Calendar Year (January 1 - December 31)

When using network professionals

If you are the only one covered by your plan, you will pay \$5,000 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 \$5,000 (\$10,000 total).
- If three or more people are covered under your plan, together you will pay \$5,000. However, no family member will pay more than \$5,000 toward the limit.

When not using network professionals

If you are the only one covered by your plan, you will pay \$6,500 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 \$6,500 (\$13,000 total).
- If three or more people are covered under your plan, together you will pay \$13,000. However, no family member will pay more than \$6,500 toward the limit.

The in-network calendar year out-of-pocket maximum includes in-network medical copays and coinsurance, and in-network pharmacy copays & coinsurance.

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

- your share of the cost routine vision care
- the cost of care received when the benefit limits have been reached
- the cost of services and supplies not covered under your Anthem KeyCare 20 plan
- the additional amount health care professionals not in our network may bill you when their charge is more than what we pay

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.

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

KeyCare 20 PPO and KeyCare 30 PPO Prescription Drug program

Your Prescription Drug 15-40-75-20% Plan	Tier 1 Copay	Tier 2 Copay	Tier 3 Copay	Tier 4 Copay
Up to a 30-day medication supply at participating pharmacies	\$15	\$40	\$75	20% coinsurance with a \$200 prescription maximum*
Up to a 90-day medication supply delivered to your home	\$38	\$100	\$188	Not Applicable
Up to a 90-day medication supply purchased at a participating** retail pharmacy	\$45	\$120	\$225	Not Applicable

**Most specialty medications are limited to up a 30 day supply regardless of whether they are retail or mail.*

Under the Affordable Care Act, prescription, medical and behavioral costs all count toward one combined out of pocket maximum. Please refer to the benefit summary included with your enrollment brochure for the out-of-pocket maximum established for your medical and pharmacy benefit.

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.

Retail 90 Pharmacy

Retail 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 Retail 90, you can choose to get a 90-day supply of medications from a participating retail pharmacy.

**Approximately 98% of the pharmacies in our network participate in the Retail 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.

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.

Your prescription drug plan (continued)

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 (*Anthem Preferred Drug List 4-Tier*)

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, 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.

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.

Your prescription drug plan (continued)

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 choose 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.

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.

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.

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.