

Your summary of benefits



Anthem® Blue Cross Life and Health Insurance Company

Your Plan: TheKey Management LLC: Zero Deductible

Your Network: BlueCard PPO

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	\$25 copay per visit
Mental Health & Substance Use Disorder Services	\$25 copay per visit
Specialist care	\$25 copay per visit

Covered Medical Benefits	Tier 1	Tier 2	Tier 3	Cost if you use an Out-of-Network Provider
Overall Deductible	\$0 person / \$0 family	\$0 person / \$0 family	\$0 person / \$0 family	Not covered
Overall Out-of-Pocket Limit	\$4,500 person / \$9,000 family	\$4,500 person / \$9,000 family	\$4,500 person / \$9,000 family	Not covered

The family out-of-pocket limit is embedded, meaning each covered person is capped at his or her per single out-of-pocket limit; in addition, cost shares for all covered family members apply to the family out-of-pocket limit, yet no one member will pay more than the per single out-of-pocket limit.

All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit.

Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*

Primary Care (PCP) and Mental Health and Substance Use Disorder Services <i>virtual and office</i>	\$15 copay per visit	\$20 copay per visit	\$35 copay per visit	Not covered
Specialist Provider <i>virtual and office</i>	\$25 copay per visit	\$35 copay per visit	\$60 copay per visit	Not covered
Other Practitioner Visits				
Maternity Doctor services				
Prenatal care The first visit with pregnancy diagnosis Tier 1 to establish \$15 copay, Tier 2 to establish \$20 copay and Tier 3 to establish \$35 copay	No Charge	No Charge	No Charge	Not covered
postpartum care and delivery	\$1,700 copay per visit	\$2,270 copay per visit	\$3,830 copay per visit	Not covered
Other Practitioner Visits				

Covered Medical Benefits	Tier 1	Tier 2	Tier 3	Cost if you use an Out-of-Network Provider
Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i>	\$15 copay per visit	\$20 copay per visit	\$35 copay per visit	Not covered
Manipulation Therapy <i>Coverage is limited to 20 visits per benefit period.</i>	\$25 copay per visit	\$35 copay per visit	\$60 copay per visit	Not covered
Acupuncture <i>Coverage is limited to 20 visits per benefit period.</i>	\$25 copay per visit	\$35 copay per visit	\$60 copay per visit	Not covered
<u>Other Services in an Office</u>				
Allergy Testing	\$25 copay per visit	\$35 copay per visit	\$60 copay per visit	Not covered
Prescription Drugs <i>Dispensed in the office</i>	\$15 copay per visit	\$20 copay per visit	\$35 copay per visit	Not covered
Surgery	\$15 copay per visit	\$20 copay per visit	\$35 copay per visit	Not covered
Preventive care / screenings / immunizations	No charge	No charge	No charge	Not covered
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	No charge	No charge	Not covered
<u>Diagnostic Services Lab</u>				
Office	\$15 copay per visit	\$20 copay per visit	\$35 copay per visit	Not covered
Freestanding Lab	\$15 copay per visit	\$20 copay per visit	\$35 copay per visit	Not covered
Outpatient Hospital	\$50 copay per visit	\$170 copay per visit	\$115 copay per visit	Not covered
<u>Diagnostic Services X-Ray</u>				
Office	\$50 copay per visit	\$70 copay per visit	\$115 copay per visit	Not covered
Freestanding Radiology Center	\$50 copay per visit	\$70 copay per visit	\$115 copay per visit	Not covered
Outpatient Hospital	\$50 copay per visit	\$70 copay per visit	\$115 copay per visit	Not covered
<u>Diagnostic Services Advanced Diagnostic Imaging</u> <i>for example: MRI, PET and CAT scans</i>				
Office	\$200 copay per visit	\$270 copay per visit	\$450 copay per visit	Not covered

Covered Medical Benefits	Tier 1	Tier 2	Tier 3	Cost if you use an Out-of-Network Provider
Freestanding Radiology Center	\$200 copay per visit	\$270 copay per visit	\$450 copay per visit	Not covered
Outpatient Hospital	\$200 copay per visit	\$270 copay per visit	\$450 copay per visit	Not covered
<u>Emergency and Urgent Care</u> Urgent Care <i>includes doctor services. Additional charges may apply depending on the care provided.</i>	\$50 copay per visit	\$50 copay per visit	\$50 copay per visit	Not covered
Emergency Room Facility Services	\$250 copay per visit	\$250 copay per visit	\$250 copay per visit	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	No charge	No charge	Covered as In-Network
Ambulance	\$250 copay per trip	\$250 copay per trip	\$250 copay per trip	Covered as In-Network
<u>Outpatient Mental Health and Substance Use Disorder Services at a Facility</u> Facility Fees	\$550 copay per visit	\$740 copay per visit	\$1,240 copay per visit	Not covered
Doctor Services	\$550 copay per visit	\$740 copay per visit	\$1,240 copay per visit	Not covered
<u>Outpatient Surgery</u> Facility Fees Hospital	\$550 copay per visit	\$740 copay per visit	\$1,240 copay per visit	Not covered
Ambulatory Surgical Center	\$550 copay per visit	\$740 copay per visit	\$1,240 copay per visit	Not covered
Physician and other services including surgeon fees Hospital	\$15 copay per visit	\$20 copay per visit	\$35 copay per visit	Not covered
<u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u> <i>If readmitted within 72 hours for the same condition, no additional facility copay is required. If transferred between facilities, only one copay will apply.</i> Facility Fees	\$1,700 copay per admission	\$2,270 copay per admission	\$3,830 copay per admission	Not covered

Covered Medical Benefits	Tier 1	Tier 2	Tier 3	Cost if you use an Out-of-Network Provider
Physician and other services <i>including surgeon fees</i>	\$15 copay per visit	\$20 copay per visit	\$35 copay per visit	Not covered
Home Health Care <i>Coverage is limited to 120 visits per benefit period.</i>	\$45 copay per visit	\$60 copay per visit	\$110 copay per visit	Not covered
Therapy Services Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies. Coverage for physical, occupational and speech therapies is limited to 60 visits combined per benefit period.</i>				
Office	\$25 copay per visit	\$35 copay per visit	\$60 copay per visit	Not covered
Outpatient Hospital	\$25 copay per visit	\$35 copay per visit	\$60 copay per visit	Not covered
Pulmonary rehabilitation <i>office and outpatient hospital</i>	\$25 copay per visit	\$35 copay per visit	\$60 copay per visit	Not covered
Cardiac rehabilitation <i>office and outpatient hospital</i>	\$25 copay per visit	\$35 copay per visit	\$60 copay per visit	Not covered
Dialysis/Hemodialysis <i>office and outpatient hospital</i>	\$25 copay per visit	\$35 copay per visit	\$60 copay per visit	Not covered
Chemo/Radiation Therapy <i>office and outpatient hospital</i>	\$25 copay per visit	\$35 copay per visit	\$60 copay per visit	Not covered
Skilled Nursing Care (facility) <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 60 days combined per benefit period.</i>	\$1,400 copay per admission	\$1,870 copay per admission	\$3,150 copay per admission	Not covered
Inpatient Hospice	\$230 copay per admission	\$310 copay per admission	\$520 copay per admission	Not covered
Additional Services, Equipment and Devices				Not covered
Durable Medical Equipment	\$95 copay per visit	\$130 copay per visit	\$215 copay per visit	Not covered
Prosthetic Devices	\$95 copay per visit	\$130 copay per visit	\$215 copay per visit	Not covered

Covered Prescription Drug Benefits	Tier 1	Tier 2	Tier 3	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable	Not applicable	Not covered
Pharmacy Out-of-Pocket Limit	Combined with Tier 1 medical out-of-pocket limit	Combined with Tier 2 medical out-of-pocket limit	Combined with Tier 3 medical out-of-pocket limit	Not covered
Prescription Drug Coverage Network: <i>Base network</i> Drug List: <i>National Direct Preferred</i> <i>If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.</i>				
Day Supply Limits: Retail Pharmacy <i>30 day supply (cost shares noted below)</i> Retail 90 Pharmacy <i>90 day supply (3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies noted below applies).</i> Home Delivery Pharmacy <i>90 day supply (maximum cost shares noted below). Maintenance medications are available through our 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.</i> Specialty Pharmacy <i>30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy. Drug cost share assistance programs may be available for certain specialty drugs.</i>				
Tier 1 - Typically Generic	\$10 copay per prescription (retail) and \$20 copay per prescription (home delivery)	\$10 copay per prescription (retail only)	\$10 copay per prescription (retail only)	Not covered
Tier 2 - Typically Preferred Brand	\$50 copay per prescription (retail) and \$100 copay per prescription (home delivery)	\$50 copay per prescription (retail only)	\$50 copay per prescription (retail only)	Not covered
Tier 3 - Typically Non-Preferred Brand	\$75 copay per prescription (retail) and \$150 copay per prescription (home delivery)	\$75 copay per prescription (retail only)	\$75 copay per prescription (retail only)	Not covered
Tier 4 - Typically Specialty (brand and generic)	\$200 copay per prescription (retail and home delivery)	\$200 copay per prescription (retail only)	\$200 copay per prescription (retail only)	Not covered

Notes:

- If you have an office visit with your Primary Care Physician, Specialist or Urgent Care 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.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
- Coverage includes standard fertility preservation services as a basic healthcare service including but are not limited to, injections, cryopreservation and storage for both male and female members when a medically necessary treatment may cause iatrogenic infertility. Member cost share for fertility preservation services is based on provider type and service rendered.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Questions: (855) 333-5730 or visit us at www.anthem.com/ca

Intentionally Left Blank

Get help in your language

Language Assistance Services

Curious to know what all this says?

We would be too. Here's the English version:

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD:711)

Separate from our language assistance program, we make documents available in alternative formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos pedirle a alguien que le ayude a leerla. También es posible que pueda solicitar que le enviemos esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721 (TTY/TDD: 711).

Arabic

هام: هل تستطيع قراءة هذه الرسالة؟ إذا لم يكن الأمر كذلك، يمكننا أن نطلب من شخص ما مساعدتك في قراءتها. قد تتمكن أيضاً من الحصول على هذه الرسالة مكتوبة بلغتك. للحصول على مساعدة مجانية، يرجى الاتصال على الفور على الرقم 1-888-254-2721. (TTY/TDD: 711)

Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք կարդալ այս նամակը: Եթե ոչ, մենք կարող ենք առաջարկել որևէ մեկի օգնությունը՝ ձեզ համար այն կարդալու համար: Դուք կարող եք նաև այս նամակը ստանալ ձեր լեզվով: Անվճար օգնության համար խնդրում ենք անմիջապես զանգահարել՝ 1-888-254-2721. (TTY/TDD: 711)

Chinese

重要：您能看此信嗎？如果不能，我們可以請人幫您看。您還可以獲得以您的語言寫的此信件。如需免費幫助，請立即致電 1-888-254-2721. (TTY/TDD:711)

Farsi

ما، توانیدمی اگر بخوانید؟ را نامه این توانید می آیا: مهم کند کمک شما به آن خواندن در خواهیم شخصی از توانیممی زبان به و کتبی صورت به را نامه این بتوانید است ممکن همچنین با فوراً لطفاً، رایگان کمک دریافت برای. کنید دریافت خودتان تماس (TTY/TDD: 711) 1-888-254-2721 شماره بگیرید.

Hindi

महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में किसी की मदद ले सकते हैं। यह पत्र आप अपनी भाषा में भी लिखवा सकते हैं। निःशुल्क सहायता के लिए, कृपया तुरंत 1-888-254-2721 पर कॉल करें। (टीटीवाई/टीडीडी:711)

Hmong

TSEEM CEEB: Koj puas nyeem tau daim ntawv no? Yog tias tsis tau, peb muaj qee tus neeg pab nyeem nws rau koj. Koj los kuj yuav tau txais ib daim ntawv sau ua kom yam lus. Rau kev pab dawb, thov hu tam sim ntawm 1-888-254-2721. (TTY/TDD: 711)

Japanese

重要：この文書を読むことができますか？読むことができない場合、支援することが可能です。また、日本語で訳されたこの文書を書面で受け取ることができます。無料の支援をご希望の場合、1-888-254-2721 (TTY/TDD:711) にご連絡ください。

Khmner

សំខាន់៖ តើអ្នកអាចអានសំបុត្រនេះបានទេ? បើអត់ទេ យើងអាចមានអ្នកជួយអាន។ អ្នកក៏អាចទទួលបានសំបុត្រនេះសរសេរជាភាសា របស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយ ឥតគិតថ្លៃ សូមទូរស័ព្ទមកភ្លាមៗតាមរយៈលេខ 1-888-254-2721. (TTY/TDD: 711)

Korean

중요: 이 편지를 읽으실 수 있으신가요?
 그렇지 않으신 경우, 이를 읽으실 수 있도록
 도움을 제공해 드릴 수 있습니다. 귀하의
 모국어로 된 편지를 우편으로 받아보실 수도
 있습니다. 무상으로 제공되는 도움이
 필요하신 경우, 1-888-254-2721번으로 바로
 연락해 주십시오. (TTY/TDD: 711)

Punjabi

ਕੀ ਤੁਸੀਂ ਇਹ ਚਿੱਠੀ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ
 ਇਸਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ
 ਇਸ ਚਿੱਠੀ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵੀ ਲਿਖ ਸਕਦੇ ਹੋ।
 ਮੁਫਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਤੁਰੰਤ ਇਸ 'ਤੇ ਕਾਲ
 ਕਰੋ 1-888-254-2721। (TTY/TDD: 711)

Russian

ВАЖНАЯ ИНФОРМАЦИЯ: Можете ли
 вы прочитать данное письмо? Если нет,
 наш специалист поможет вам в этом.
 Вы также можете получить данное
 письмо на вашем языке. Для получения
 бесплатной помощи звоните по номеру
 1-888-254-2721. (TTY/TDD: 711)

Tagalog

MAHALAGA: Mababasa mo ba ang
 sulat na ito? Kung hindi, mayroon kaming
 makakatulong sa iyo na basahin ito.
 Maaari mo ring makuha ang sulat na ito
 nang nakasulat sa iyong wika. Para sa
 libreng tulong, mangyaring tumawag
 kaagad sa 1-888-254-2721.
 (TTY/TDD: 711)

Thai

สำคัญ: คุณสามารถอ่านจดหมายนี้ได้หรือไม่
 หากคุณอ่านจดหมายนี้ไม่ได้ เราสามารถขอให้
 ใครสักคนช่วยคุณอ่านได้ คุณสามารถร้องขอ
 จดหมายนี้ที่เขียนในภาษาของคุณได้เช่นกัน
 หากต้องการความช่วยเหลือแบบไม่มีค่าใช้จ่าย
 โปรดโทรหาเราได้ทันทีที่ 1-888-254-2721.
 (TTY/TDD: 711)

Vietnamese

QUAN TRỌNG: Quý vị có đọc được lá thư
 này không? Nếu không, chúng tôi có thể
 nhờ ai đó giúp quý vị đọc. Quý vị cũng có
 thể yêu cầu thư này viết bằng ngôn ngữ
 của quý vị. Để được trợ giúp miễn phí,
 hãy gọi ngay đến số 1-888-254-2721.
 (TTY/TDD: 711)

It's important we treat you fairly

We follow state and federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services, in a timely manner, like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or if you think you were discriminated against based on race, color, national origin, age, disability, or sex, you can mail a complaint directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800-368-1019 (TDD: 1-800-537-7697) or visit <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>