Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Plan: CUSTOM

Your School: HAMPTON UNIVERSITY - SHIP

Your Network: KeyCare

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$0 student person	$0 student person
Out-of-Pocket Limit	$3,000 person / $6,000 family	$3,000 person / $6,000 family
The family out-of-pocket maximum is embedded, meaning the cost shares of one family member will be applied to the per person out-of-pocket maximum; in addition, amounts for all covered family members apply to the family out-of-pocket maximum. No one member will pay more than the per person out-of-pocket maximum. All medical and prescription drugs deductibles, copayments and coinsurance apply toward the out-of-pocket maximum. In-network and out-of-network out-of-pocket maximum amounts are combined and do accumulate toward each other.		
Preventive Care / Screening / Immunization	No charge	30% coinsurance
Virtual Care (Telemedicine / Telehealth Visits)		
Virtual Visits with Doctors who also provide services in person		
Primary Care (PCP)	$25 copay per visit	$25 copay per visit and 30% coinsurance
Mental Health and Substance Abuse Care	$25 copay per visit	30% coinsurance
Specialist Care	$25 copay per visit	$25 copay per visit and 30% coinsurance

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 Care	$25 copay per visit	$25 copay per visit and 30% coinsurance
Specialist Care	$25 copay per visit	$25 copay per visit and 30% coinsurance
Visits in an Office		
Primary Care (PCP)	$25 copay per visit	$25 copay per visit and 30% coinsurance
Specialist Care	$25 copay per visit	$25 copay per visit and 30% coinsurance
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal) *In-Network routine prenatal office visits and other preventive prenatal care and screening are covered at 100%.*	$25 copay per pregnancy	30% coinsurance
Retail Health Clinic	$25 copay per visit	30% coinsurance
Manipulation Therapy *Coverage is limited to 30 visits per benefit period.*	$25 copay per visit	$25 copay per visit and 30% coinsurance
Acupuncture	$25 copay per visit	$25 copay per visit and 30% coinsurance
Other Services in an Office		
Allergy Testing	20% coinsurance	30% coinsurance
Chemo/Radiation Therapy	20% coinsurance	30% coinsurance
Dialysis/Hemodialysis	20% coinsurance	30% coinsurance
Prescription Drugs - *Dispensed in the office*	20% coinsurance	30% coinsurance
Surgery	20% coinsurance	30% coinsurance

Diagnostic Services **Lab**		
Office	20% coinsurance	30% coinsurance
Preferred Reference Lab	20% coinsurance	30% coinsurance
Outpatient Hospital	20% coinsurance	30% coinsurance
X-Ray		
Office	20% coinsurance	30% coinsurance
Freestanding Radiology Center	20% coinsurance	30% coinsurance
Outpatient Hospital	20% coinsurance	30% coinsurance
Advanced Diagnostic Imaging		
Office	20% coinsurance	30% coinsurance
Freestanding Radiology Center	20% coinsurance	30% coinsurance
Outpatient Hospital	20% coinsurance	30% coinsurance
Emergency and Urgent Care		
Urgent Care	$25 copay per visit	$25 copay per visit and 30% coinsurance
Emergency Room Facility Services	$150 copay per visit and 20% coinsurance	$150 copay per visit and 20% coinsurance
Emergency Room Doctor and Other Services	20% coinsurance	20% coinsurance
Ambulance	20% coinsurance	20% coinsurance

Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	$25 copay per visit	30% coinsurance
Facility Visit		
Facility Fees	20% coinsurance	30% coinsurance
Doctor Services	20% coinsurance	30% coinsurance
Outpatient Surgery		
Facility Fees		
Hospital	20% coinsurance	30% coinsurance
Freestanding Surgical Center	20% coinsurance	30% coinsurance
Doctor and Other Services		
Hospital	20% coinsurance	30% coinsurance
Freestanding Surgical Center	20% coinsurance	30% coinsurance
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse)		
Facility Fees *Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 100 days combined per admission.*	20% coinsurance	30% coinsurance
Human Organ and Tissue Transplants *Coverage includes acquisition and transplant procedures, collection and storage.*	20% coinsurance	30% coinsurance
Doctor and other services	20% coinsurance	30% coinsurance
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 100 visits per benefit period.*	20% coinsurance	30% coinsurance

Rehabilitation services *Coverage for speech therapy is limited to 30 visits per benefit period. Coverage for rehabilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period. Benefit limit does not apply to Applied Behavioral Analysis. Benefit limit does not apply when performed as part of Early Intervention.*		
Office	$25 copay per visit	$25 copay per visit and 30% coinsurance
Outpatient Hospital	$25 copay per visit	$25 copay per visit and 30% coinsurance
Habilitation services *Coverage for speech therapy is limited to 30 visits per benefit period. Coverage for habilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period. Benefit limit does not apply to Applied Behavioral Analysis.*		
Office	$25 copay per visit	30% coinsurance after medical deductible is met
Outpatient Hospital	$25 copay per visit	30% coinsurance after medical deductible is met
Cardiac rehabilitation		
Office	$25 copay per visit	$25 copay per visit and 30% coinsurance
Outpatient Hospital	$25 copay per visit	$25 copay per visit and 30% coinsurance
Skilled Nursing Care (facility) *Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 120 days combined per benefit period.*	20% coinsurance	30% coinsurance
Inpatient Hospice	20% coinsurance	30% coinsurance
Durable Medical Equipment	20% coinsurance	30% coinsurance
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	20% coinsurance	30% coinsurance

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out of Pocket Limit	Combined with medical out-of-pocket limit	Combined with medical out-of-pocket limit
Prescription Drug Coverage *Cost shares for drugs included on the Traditional Open 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.*		
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy and Retail 90 pharmacy).*	$5 copay per prescription, Pharmacy deductible does not apply (retail) and Not covered (home delivery)	30% coinsurance up to $100 per prescription, Pharmacy deductible does not apply (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy).*	$15 copay per prescription, Pharmacy deductible does not apply (retail) and Not covered (home delivery)	30% coinsurance up to $200 per prescription, Pharmacy deductible does not apply (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy).*	$40 copay per prescription, Pharmacy deductible does not apply (retail) and Not covered (home delivery)	30% coinsurance, Pharmacy deductible does not apply (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) *Per 30 day supply (specialty pharmacy).*	$40 copay per prescription after Pharmacy deductible is met (retail) and Not covered (home delivery)	30% coinsurance up to $400 per prescription after Pharmacy deductible is met (retail) and Not covered (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 Essential Health Benefits (up to age 19) **Vision exam** *Limited to 1 exam per benefit period.*	No charge	Reimbursed Up to $30
Frames *Limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $45
Lenses *Limited to 1 unit per benefit period combined with OON Coverage. OON Reimbursement: Single* Reimbursed Up to $25*, Bifocal* Reimbursed Up to $40*, Trifocal* Reimbursed Up to $55*.*	No charge	Receives Reimbursement
Elective Contact Lenses *Limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $60
Non-Elective Contact Lenses *Limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $210

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your dental coverage. Only children's dental services count towards your out of pocket limit.		
Children's Dental Essential Health Benefits (up to age 19) **Diagnostic and preventive** *Limited to 2 visits per 12 months.*	No charge	No charge
Basic services	50% coinsurance	50% coinsurance
Major services	50% coinsurance	50% coinsurance
Medically Necessary Orthodontia services	50% coinsurance	50% coinsurance
Cosmetic Orthodontia services	Not covered	Not covered
Deductible	Not applicable	Not applicable
Adult Dental	Not covered	Not covered

Notes:

- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- When using a non-network pharmacy, members are responsible for the stated copay & costs in excess of the prescription drug maximum allowed amount. Members will pay upfront and submit a claim form.

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 to the applicable Anthem enrollment brochure.

Exclusions

Medical

In this section you will find a review of items that are not covered by your Plan. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by your Plan. We will have the right to make the final decision about whether services or supplies are Medically Necessary and if they will be covered by your Plan.

1. Acts of War, Disasters, or Nuclear Accidents
2. Administrative Charges
3. Alternative / Complementary Medicine
4. Charges Over the Maximum Allowed Amount
5. Cosmetic Services
6. Court Ordered Testing
7. Custodial Care
8. Experimental or Investigational Services
9. Eyeglasses and Contact Lenses
10. Health Club Memberships and Fitness Services
11. Non-Medically Necessary Services
12. Nutritional or Dietary Supplements
13. Personal Care and Convenience items
14. Private Duty Nursing
15. Stand-By Charges
16. Travel Costs
17. Vision Services
18. Weight Loss Programs

Exclusions

Pharmacy

In addition to the above Exclusions, certain items are not covered under the Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy benefit:

1. Clinically-Equivalent Alternatives
2. Compound Drugs
3. Drugs Prescribed by Providers Lacking Qualifications/ Registrations/Certifications
4. Drugs That Do Not Need a Prescription
5. Lost or Stolen Drugs
6. Non-approved Drugs
7. Nutritional or Dietary Supplements
8. Off label use
9. Over-the-Counter Items
10. Weight Loss Drugs

Language Access Services:

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
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 844-412-0752

Separate from our language assistance program, we make documents available in alternate 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.

(TTY/TDD: 711)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على 844-412-0752 .

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ 844-412-0752:

Chinese(中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電844-412-0752。

Farsi (فارسي) : در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره 844-412-0752 تماس بگیرید.

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le 844-412-0752.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele 844-412-0752.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero 844-412-0752.

Japanese (日本語):この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。 通訳と話すには、844-412-0752 にお電話ください。

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면844-412-0752로 문의하십시오.

Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'idiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí łą' bich'į' hadeesdzih ninízingo kojį' hodíilnih 844-412-0752.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: 844-412-0752.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 844-412-0752 ਤੇ ਕਾਲ ਕਰੋ।

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. 844-412-0752.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al 844-412-0752.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang 844-412-0752.

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi 844-412-0752.

It's important we treat you fairly
That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with 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 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.