Your summary of benefits

Anthem BlueCross BlueShield

Associated Universities/NRAO January 1, 2020 - December 31, 2020

Anthem Blue Cross and Blue Shield

Your Plan: Anthem HSA 1500/10%/3750 Custom
HRA 1500/10%/3750 Custom

Your Network: KeyCare

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.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$1,500 person / $3,000 family	$3,000 person / $6,000 family
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.*	$3,750 person / $6,650 person in a family/ $7,500 family	$7,500 person / $7,500 person in a family/ $12,000 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	30% coinsurance after deductible is met
Doctor Home and Office Services		
Primary care visit to treat an injury or illness	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Specialist care visit	10% coinsurance after deductible is met	30% coinsurance after deductible is met

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Prenatal and Post-natal Care	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Other practitioner visits:		
Retail health clinic	10% coinsurance after deductible is met	30% coinsurance after deductible is met
On-line Medical Visit *Live Health Online is* the *preferred telehealth solutions (www.livehealthonline.com)*	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Chiropractic services *Coverage for In-Network Provider and Non-Network Provider combined is unlimited visits for Rehabilitation and Habilitative per benefit period.*	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Other services in an office:		
Allergy testing	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Chemo/radiation therapy	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Dialysis/Hemodialysis	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Prescription drugs *For the drugs itself dispensed in the office thru infusion/injection*]	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Diagnostic Services		
Lab: Office	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Preferred Reference Lab	10% coinsurance after deductible is met	30% coinsurance after deductible is met

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Outpatient Hospital	10% coinsurance after deductible is met	30% coinsurance after deductible is met
X-ray:		
Office	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Radiology Center	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Radiology Center	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Emergency and Urgent Care		
Emergency room facility services	10% coinsurance after deductible is met	Covered as In-Network
Emergency room doctor and other services	10% coinsurance after deductible is met	Covered as In-Network
Ambulance Transportation	10% coinsurance after deductible is met	Covered as In-Network

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Urgent Care Center Office Visit	10% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder		
Doctor Office Visit and Online Visit	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Facility visit:		
Facility fees	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor Services	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Surgery		
Facility fees:		
Hospital	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Surgical Center	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor and other services **S**urgery	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Hospital Stay (all inpatient stays including maternity, mental and substance use disorder)		
Facility fees (for example, room & board)	10% coinsurance after deductible is met	30% coinsurance after deductible is met

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Doctor and other services	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Recovery & Rehabilitation		
Home health care *Coverage for In-Network and Non-Network Provider combined is limited to 40 visits per benefit period. Visit limit does not apply to Home Infusion Therapy or Home Dialysis.*	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is unlimited visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is unlimited visits per benefit period. Applies to In-Network Provider and Non-Network Provider combined. Visit limit does not apply when performed as part of Hospice, Home Health, Early Intervention or Autism services. Visit limits are combined both across outpatient and other professional visits, and in and out of network.*	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient hospital *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is unlimited visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is unlimited visits per benefit period. Applies to In-Network Provider and Non-Network Provider combined. Visit limit does not apply when performed as part of Hospice, Home Health, Early Intervention or Autism services. Visit limits are combined both across outpatient and other professional visits, and in and out of network.*	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Habilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is unlimited visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is unlimited visits per benefit period. Applies to In-Network Provider and Non-Network*	10% coinsurance after deductible is met	30% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Provider combined. Visit limit does not apply when performed as part of Hospice, Home Health, Early Intervention or Autism services. Visit limits are combined both across outpatient and other professional visits, and in and out of network.		
Outpatient hospital *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is unlimited visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is unlimited visits per benefit period. Applies to In-Network Provider and Non-Network Provider combined. Visit limit does not apply when performed as part of Hospice, Home Health, Early Intervention or Autism services. Visit limits are combined both across outpatient and other professional visits, and in and out of network.*	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Cardiac rehabilitation		
Office Visit	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient hospital	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Skilled nursing care (in a facility) *Coverage for Inpatient rehabilitation and skilled nursing services combined In-Network Provider and Non-Network Provider combined is limited to 60 days per admission.*	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Hospice	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Durable Medical Equipment	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs needed after cancer treatment In-Network and Non-Network Provider combined is limited to 1 unit per benefit period.*	10% coinsurance after deductible is met	30% coinsurance after deductible is met

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Combined with medical deductible	Combined with medical deductible
Pharmacy Out of Pocket	Combined with medical out of pocket	Combined with medical out of pocket
Prescription Drug Coverage *Anthem Essential Drug List* *This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.*		
Tier 1 - Typically Generic *You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Covers up to a 30 day supply (retail pharmacy). Covers up to 90 day supply (retail maintenance pharmacy) Covers up to a 90 day supply (home delivery program.) No coverage for non-formulary drugs. Note: A 90 day supply is available at retail maintenance pharmacies with a copay for each 30 day supply. Coverage is also provided at retail for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time.* *PreventiveRX Plus (Essential) Medications covered: No Charge, No Deductible*	20% coinsurance per prescription after deductible is met (retail only). 15% coinsurance per prescription after deductible is met (home delivery only).	30% coinsurance after deductible is met(retail and home delivery).
Tier 2 - Typically Preferred Brand & Non-Preferred Generics *You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Covers up to a 30 day supply (retail pharmacy). Covers up to 90 day supply (retail maintenance pharmacy) Covers up to a 90 day supply (home delivery program.) No coverage for non-formulary drugs. Note: A 90 day supply is available at retail maintenance pharmacies with a copay for each 30 day supply. Coverage is also provided at retail for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time.* *PreventiveRX Plus (Essential) Medications covered: No Charge, No Deductible*	40% coinsurance per prescription after deductible is met (retail only). 35% coinsurance per prescription after deductible is met (home delivery only).	30% coinsurance after deductible is met(retail and home delivery).
Tier 3 - Typically Non-Preferred Brand *You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Covers up to a 30 day supply (retail pharmacy). Covers up to 90 day supply (retail maintenance pharmacy) Covers up to a 90 day supply (home delivery program.) No coverage for non-formulary drugs. Note: A 90 day supply is available at retail maintenance pharmacies with a copay for each 30 day supply. Coverage is also provided at retail for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time.*	50% coinsurance per prescription after deductible is met (retail only). 45% coinsurance per prescription after deductible is	30% coinsurance after deductible is met(retail and home delivery).

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
	met (home delivery only).	
Tier 4 - Typically Preferred Specialty (brand and generic) *You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Covers up to a 30 day supply (retail pharmacy). Covers up to 30 day supply (home delivery program.) Note: Coverage is also provided at retail for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time. No coverage for non-formulary drugs.*	50% coinsurance per prescription after deductible is met (retail only). 45% coinsurance per prescription after deductible is met (retail and home delivery).	30% coinsurance after deductible is met(retail and home delivery).

Your summary of benefits

Covered Vision Benefits, included with your medical plan. (A separate, voluntary plan is also available and those details follow later in this booklet.)	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. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail.		
Child Vision exam *Coverage for In-Network Providers is limited to 1 exam per benefit period.*	No charge	$30 reimbursement
Adult Vision exam *Coverage for In-Network Providers is limited to 1 exam per benefit period.*	$15 copay per visit	$30 reimbursement

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Notes:

- The family deductible is non-embedded, meaning the cost shares of all family members apply to one shared family deductible and one shared family out-of-pocket maximum. The individual deductible only applies to individuals enrolled under single coverage.
- The out-of-pocket maximum is embedded, meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to the family out-of-pocket maximum. No one member will pay more than the individual in a family out-of-pocket maximum.
- Your coinsurance, copays and deductible count toward your out of pocket amount.
- Deductible and Out-of-Pocket maximums will accumulate in one direction (that is, Out-of-Network will accumulate to In Network). All other plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and Out-of-Network unless otherwise noted.
- All medical services subject to a coinsurance are also subject to the annual medical deductible, if deductible is applicable to plan.
- If your plan includes a hospital stay copay and you are readmitted within 72 hours of a prior admission for the same diagnosis, your hospital stay copay for your readmission is waived.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- In-network preventive care is not subject to deductible, if your plan has a deductible
- If your plan includes out of network benefits and you use a non-participating provider, you are responsible for any difference between the covered expense and the actual non-participating providers charge.When receiving care from providers out of network, members may be subject to balance billing in addition to any applicable copayments, coinsurance and/or deductible. This amount does not apply to the out of network out of pocket limit.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.
- Plan includes coverage for Infertility including, artificial insemination, in-vitro fertilization, GIFT, ZIFT with an unlimited lifetime maximum.
- Hearing aids are covered as any other service up to $3,500 per calendar year.
- Accupuncutre services are covered as any other service up to $3,000 per calendar year.

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) 682-6553.

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) 682-6553.

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) 682-6553:

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) 682-6553。

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) 682-6553 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) 682-6553.

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) 682-6553.

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) 682-6553.

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) 682-6553 にお電話ください。

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Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bína'ídíłkidgo ná bohónéedzą́ dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínízingo kojį' hodíílnih (844) 682-6553.

Language Access Services:

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) 682-6553.

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) 682-6553 ਤੇ ਕਾਲ ਕਰੋ।

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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) 682-6553.

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) 682-6553.

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) 682-6553.

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.