

# Your summary of benefits



## Anthem. HealthKeepers

Anthem® HealthKeepers Inc.

Your Contract Code: Modified

Your Plan: Anthem HealthKeepers Advantage OA 25 750/20%/ 4500 Rx \$10/\$40/\$70/20%

Your Network: HealthKeepers

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
<b>Primary Care, and medical services for urgent/acute care</b>	\$0 copay per visit medical deductible does not apply
<b>Mental Health &amp; Substance Use Disorder Services</b>	\$0 copay per visit medical deductible does not apply
<b>Specialist care</b>	\$50 copay per visit medical deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b>	\$ 750 person / \$ 1,500 family	\$ 1,500 person / \$ 3,000 family
<b>Overall Out-of-Pocket Limit</b>	\$ 4,500 person / \$ 9,000 family	\$ 11,250 person / \$ 22,500 family

The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit.

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

In-Network and Non-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.

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

<b>Preferred PCP</b> <i>virtual and office</i>	\$15 copay per visit medical deductible does not apply	Not covered
<b>Primary Care (PCP)</b> <i>virtual and office</i>	\$25 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Mental Health and Substance Use Disorder Services</b> <i>virtual and office</i>	\$25 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
<b>Specialist Care</b> <i>virtual and office</i>	\$50 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
<u><b>Other Practitioner Visits</b></u>  <b>Routine Maternity Care</b> (Prenatal and Postnatal)  <b>Retail Health Clinic</b> <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i>  <b>Manipulation Therapy</b> <i>Coverage is limited to 30 visits per benefit period.</i>	  20% coinsurance after medical deductible is met  \$25 copay per visit medical deductible does not apply  \$25 copay per visit medical deductible does not apply	  30% coinsurance after medical deductible is met  30% coinsurance after medical deductible is met  30% coinsurance after medical deductible is met  30% coinsurance after medical deductible is met
<u><b>Other Services in an Office</b></u>  <b>Allergy Testing</b>  <b>Prescription Drugs</b> <i>Dispensed in the office</i>  <b>Surgery</b>	  \$15 copay per visit medical deductible does not apply  20% coinsurance after medical deductible is met  20% coinsurance after medical deductible is met	  30% coinsurance after medical deductible is met  30% coinsurance after medical deductible is met  30% coinsurance after medical deductible is met
<b>Preventive care / screenings / immunizations</b>	No charge	30% coinsurance after medical deductible is met
<b>Preventive Care for Chronic Conditions</b> <i>per IRS guidelines</i>	No charge	30% coinsurance after medical deductible is met
<u><b>Diagnostic Services</b></u> <b>Lab</b> Office	No charge	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Preferred Reference Lab	No charge	30% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
<b>X-Ray</b>		
Office	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
<b>Advanced Diagnostic Imaging</b> <i>for example: MRI, PET and CAT scans</i>		
Office	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
<b><u>Emergency and Urgent Care</u></b>		
<b>Urgent Care</b> <i>includes doctor services. Additional charges may apply depending on the care provided.</i>	\$50 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
<b>Emergency Room Facility Services</b>	20% coinsurance after medical deductible is met	Covered as In-Network
<b>Emergency Room Doctor and Other Services</b>	20% coinsurance after medical deductible is met	Covered as In-Network
<b>Ambulance</b>	20% coinsurance after medical deductible is met	Covered as In-Network
<b>Outpatient Mental Health and Substance Use Disorder Services at a Facility</b>		
Facility Fees	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Doctor Services	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
<p><b><u>Outpatient Surgery</u></b></p> <p><b>Facility Fees</b></p> <p>Hospital</p> <p>Ambulatory Surgical Center</p> <p><b>Physician and other services</b> <i>including surgeon fees</i></p> <p>Hospital</p>	<p>20% coinsurance after medical deductible is met</p> <p>\$300 copay per visit medical deductible does not apply</p> <p>20% coinsurance after medical deductible is met</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>
<p><b><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u></b></p> <p><b>Facility Fees</b></p> <p><b>Physician and other services</b> <i>including surgeon fees</i></p>	<p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>
<p><b>Home Health Care</b>  <i>Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.</i></p>	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
<p><b>Rehabilitation and Habilitation services</b> <i>including physical, occupational and speech therapies.</i>  <i>Coverage for physical and occupational therapies is limited to 30 visits combined per benefit period. Coverage for speech therapy is limited to 30 visits per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$25 copay per visit medical deductible does not apply</p> <p>20% coinsurance after medical deductible is met</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Pulmonary rehabilitation</b> <i>office and outpatient hospital</i>	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
<b>Cardiac rehabilitation</b> <i>office and outpatient hospital</i> <i>Coverage is limited to 36 visits per benefit period.</i>	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
<b>Dialysis/Hemodialysis</b> <i>office and outpatient hospital</i>	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
<b>Chemo/Radiation Therapy</b> <i>office and outpatient hospital</i>	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
<b>Skilled Nursing Care (facility)</b> <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.</i>	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
<b>Inpatient Hospice</b>	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
<b>Durable Medical Equipment</b>	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
<b>Prosthetic Devices</b> <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
<b>Hearing Aids</b> <i>Coverage is limited to 1 item, up to \$1,500 per hearing-impaired ear, every 24 months for members through age 18.</i>	No charge	30% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<b>Pharmacy Deductible</b>	Not applicable	Not applicable
<b>Pharmacy Out-of-Pocket Limit</b>	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
<b>Prescription Drug Coverage</b>		

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<p><b>Network: Base Network</b>  <b>Drug List: Essential</b> Drugs not included on the Essential drug list will not be covered.</p>		
<p><b>Day Supply Limits:</b>  <b>Retail Pharmacy</b> 30 day supply (cost shares noted below)  <b>Retail 90 Pharmacy</b> 90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).  <b>Home Delivery Pharmacy</b> 90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail. You will need to call us on the number on your ID card to sign up when you first use the service.  <b>Specialty Pharmacy</b> 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.</p>		
Tier 1 - Typically Generic	\$10 copay per prescription (retail) and \$ 25 copay per prescription (home delivery)	30% coinsurance (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand	\$40 copay per prescription (retail) and \$100 copay per prescription (home delivery)	30% coinsurance (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	\$70 copay per prescription (retail) and \$175 copay per prescription (home delivery)	30% coinsurance (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	20% coinsurance up to \$300 per prescription (retail and home delivery)	30% coinsurance (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
<p><i>This is a brief outline of your vision coverage. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out-of-pocket limit.</i></p>		
<p><b>Children's Vision exam (up to age 19)</b>  <i>Limited to 1 exam per benefit period.</i></p>	No charge	\$0 copayment up to plan's Maximum Allowed Amount
<p><b>Adult Vision exam (age 19 and older)</b>  <i>Limited to 1 exam per benefit period.</i></p>	\$15 copay	Reimbursed Up to \$30

**Notes:**

- If you have an office visit with your Primary Care Physician or Specialist 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 representations of benefits in this document are subject to Virginia Bureau of Insurance (BOI) approval and are subject to change.

*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 on limitations and exclusions that apply to our medical plans. Visit <https://www.anthemplancomparison.com/va> to access this information.*

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Questions: (833) 592-9956 or visit us at [www.anthem.com](http://www.anthem.com)



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## 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 (833) 592-9956

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 (833) 592-9956

**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՝ (833) 592-9956:

**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(833) 592-9956。

**Farsi (فارسی):** 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 (833) 592-9956 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 (833) 592-9956.

**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 (833) 592-9956.

**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 (833) 592-9956.

**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、(833) 592-9956 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 이야기하려면(833) 592-9956로 문의하십시오.

**Navajo (Diné):** Díí naaltsoos biká'ígíí lahgo bina'ídiłkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj bee níl hodoonih t'áadoo báąh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih nínízingo kojí' hodiłlnih (833) 592-9956.

## 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: (833) 592-9956.

**Punjabi (ਪੰਜਾਬੀ):** ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (833) 592-9956 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. (833) 592-9956.

**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 (833) 592-9956.

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### 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>.