Your summary of benefits

Anthem HealthKeepers

Your Plan: Anthem HealthKeepers Platinum OAPOS 10/20%/3000

Your Network: HealthKeepers

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 contract of coverage. If there is a difference between this summary and the contract of coverage, the contract of coverage will prevail.

Covered Medical Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
Overall Deductible *See notes section at the end of the document to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Retail Prescription Drug Coverage section.*	Member: None For Family: None	Member: $2,000 For Family: $4,000
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 at the end of the document for additional information regarding your out of pocket maximum.* *For prescription drug, all cost shares count towards your plan's annual out-of-pocket limit.*	Member: $3,000 For Family: $6,000	Member: $6,000 For Family: $12,000
Doctor Home and Office Services		
Preventive care *In-network preventive care is not subject to deductible, if your plan has a deductible.*	Covered in full	30% coinsurance after deductible
Primary care visit to treat an injury or illness	$10 copay	30% coinsurance after deductible
Specialist care visit	$35 copay	30% coinsurance after deductible
Prenatal and postpartum care *Copay per pregnancy*	$250 copay	30% coinsurance after deductible

Covered Medical Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
Doctor Home and Office Services (*continued*)		
Other practitioner visits:		
Retail health clinic	$10 copay	30% coinsurance after deductible
On-line visit	$10 copay	30% coinsurance after deductible
Chiropractor services *Limited to 30 manipulative treatment visits. Visit limit is combined both across outpatient and other professional visits, and in and out of network.*	$10 copay	30% coinsurance after deductible
Other services in an office:		
Allergy testing	$10 copay	30% coinsurance after deductible
Chemo/radiation therapy	20% coinsurance	30% coinsurance after deductible
Hemodialysis	20% coinsurance	30% coinsurance after deductible
Prescription drugs	20% coinsurance	30% coinsurance after deductible

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Covered Medical Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
Diagnostic Services		
Lab:		
Freestanding/Reference Labs	Covered in full	30% coinsurance after deductible
Office *Office cost share applies only when Freestanding/Reference lab is not used.*	20% coinsurance	30% coinsurance after deductible
Outpatient hospital	20% coinsurance	30% coinsurance after deductible
X-ray:		
Office	20% coinsurance	30% coinsurance after deductible
Freestanding radiology center	20% coinsurance	
Outpatient hospital	20% coinsurance	30% coinsurance after deductible
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office	20% coinsurance	30% coinsurance after deductible
Freestanding radiology center	20% coinsurance	
Outpatient hospital	20% coinsurance	30% coinsurance after deductible

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Covered Medical Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
Emergency and Urgent Care		
Urgent care (office setting)	$35 copay	30% coinsurance after deductible
Emergency room facility services	$200 copay	Same as In Network
Emergency room doctor and other services	20% coinsurance	Same as In Network
Ambulance (air and ground)	20% coinsurance	Same as In Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit	$10 copay	30% coinsurance after deductible
Facility visit:		
Facility fees	$250 copay	30% coinsurance after deductible
Doctor services	20% coinsurance	30% coinsurance after deductible
Outpatient Surgery		
Facility fee:		
Freestanding surgical center	$250 copay	
Hospital	$250 copay	30% coinsurance after deductible
Doctor services:		
Freestanding surgical center	20% coinsurance	
Hospital	20% coinsurance	30% coinsurance after deductible

Covered Medical Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse) **Facility fee (for example, room & board)**	$500 copay per day up to 3 days	30% coinsurance after deductible
Doctor and other services	20% coinsurance	30% coinsurance after deductible
Recovery & Rehabilitation **Home health care** *Limited to 100 combined visits per benefit period and is combined in and out of network. Visit limit does not apply to Home Infusion Therapy or Home Dialysis. Private Duty Nursing Home Care is limited to 16 hours per benefit period and is combined in and out of network.*	$10 copay	30% coinsurance after deductible
Rehabilitation services **(for example, physical/speech/occupational therapy):** Office Outpatient hospital *Limited to 30 combined visits for rehabilitative/habilitative Physical and Occupational Therapy services. Visit limit does not apply when performed as part of Hospice. When rehabiitative physical therapy is rendered in the home, the Home Care visit limit applies instead of the Therapy Services limits. Visit limits are combined both across outpatient and other professional visits, and in and out of network.*	$10 copay 20% coinsurance	30% coinsurance after deductible 30% coinsurance after deductible
Cardiac rehabilitation Office Outpatient hospital	$35 copay 20% coinsurance	30% coinsurance after deductible 30% coinsurance after deductible
Skilled nursing care (in a facility) *Limited to 100 combined days per admission for Skilled Nursing Facility and Inpatient Rehabilitation services . Day limit is combined in and out of network.*	$500 copayper day up to 3 days	30% coinsurance after deductible
Durable medical equipment & prosthetics	20% coinsurance	30% coinsurance after deductible

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Covered Prescription Drug Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
Retail Prescription Drug Coverage ***This plan uses an Anthem National Drug List. Drugs not on the list are not covered.*** ***This plan includes Home Delivery (Mail Order), Home Delivery copays are 2.5 [Tier 1], 3.0 [Tier 2], 3.0 [Tier 3] times retail copays and select drugs are available for up to a 90 day supply.*** ***Retail pharmacy and Specialty drugs are each limited to a 30 day supply. Limits are combined in and out of network.*** ***If you purchase a brand name drug when a generic drug is available, you will be responsible for paying the brand name copayment plus the difference in cost between the cost of the generic drug and the cost of the brand name drug.***		
Drug tier 1 - Typically Generic	$5 copay	30% coinsurance
Drug tier 2 - Typically Preferred / Formulary Brand	$35 copay	30% coinsurance
Drug tier 3 - Typically Non-preferred/Non-formulary and Specialty Drugs	$60 copay	30% coinsurance
Drug tier 4 - Typically Specialty Drugs	25% coinsurance	30% coinsurance
Drug tier 4 per-prescription maximum cost share	$250	Not applicable

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Covered Vision Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-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. *Only children's vision services count towards your out of pocket limit.*	*Eye exams are covered once per benefit period and are combined in and out-of-network. For children through age 18: There is a selection of frames and contact lenses that are covered under this plan. Eyeglass lenses and frames are covered once per benefit period. Contact lens benefit is available only if the eyeglass lens benefit is not used. Review the formal contract of coverage or contact your vision provider for more information.*	*For covered services with a reimbursement amount, you will have no cost share up to that amount. All costs beyond the reimbursement amount are subject to balance billing.*
Children's Vision Essential Health Benefits		
Vision exam	$0 copay	$30 reimbursement
Frames	$0 copay	$45 reimbursement
Lenses		
Single	$0 copay	$25 reimbursement
Bifocal	$0 copay	$40 reimbursement
Trifocal	$0 copay	$55 reimbursement
Elective Contact Lenses	$0 copay	$60 reimbursement
Non-Elective Contact Lenses	$0 copay	$210 reimbursement

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Covered Vision Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
Adult Vision Benefits		
Vision exam	$20 copay	$30 reimbursement
Frames	Not covered	Not covered
Lenses		
Single	Not covered	Not covered
Bifocal	Not covered	Not covered
Trifocal	Not covered	Not covered
Elective Contact Lenses	Not covered	Not covered
Non-Elective Contact Lenses	Not covered	Not covered

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Covered Dental Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
This is a brief outline of your dental 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. *Children's dental services count towards your out of pocket limit.*		
Children's Dental Essential Health Benefits **Diagnostic and preventive**	10% coinsurance	30% coinsurance
Basic services	40% coinsurance after deductible	50% coinsurance after deductible
Major services	50% coinsurance after deductible	50% coinsurance after deductible
Medically Necessary Orthodontia services	50% coinsurance after deductible	50% coinsurance after deductible
Cosmetic Orthodontia services	Not covered	Not covered
Deductible (Applies to all services except diagnostic & preventive)	None	Combined with Medical
Out-of-Pocket Limit	Combined with Medical	Combined with Medical
Adult Dental Benefits **Diagnostic and preventive**	Not covered	Not covered
Basic services	Not covered	Not covered
Major services	Not covered	Not covered
Deductible	Not covered	Not covered
Out-of-Pocket Limit	Not covered	Not covered

Notes:

• The family deductible and out-of-pocket maximum are 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 deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.

• Your copays, coinsurance and deductible count toward your out of pocket amount.

• 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 an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.

• 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.

• 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.

• For members who are pregnant and change doctors during pregnancy, or if a pregnancy ends prior to delivery or completion of care, the prenatal and postpartum services will be billed separately by your physicians.

• Wigs needed after cancer treatment are limited to one wig per benefit period.

• 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.

• For additional information on limitations and exclusions that apply to this plan, go to sgplans.anthem.com/va/le/bcbs.

• To view your prescription formulary list log on to www.anthem.com/health-insurance/customer-care/forms-library.

• For additional information on this plan, please visit sbc.anthem.com to obtain a “Summary of Benefit Coverage”.