

Your summary of benefits



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 <i>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.</i>	Member: None For Family: None	Member: \$2,000 For Family: \$4,000
Out-of-Pocket Limit <i>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.</i> <i>For prescription drug, all cost shares count towards your plan's annual out-of-pocket limit.</i>	Member: \$3,000 For Family: \$6,000	Member: \$6,000 For Family: \$12,000
Doctor Home and Office Services Preventive care <i>In-network preventive care is not subject to deductible, if your plan has a deductible.</i>	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 post-natal care	\$250 copay per pregnancy	30% coinsurance after deductible

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Doctor Home and Office Services (continued)		
<p>Other practitioner visits:</p> <ul style="list-style-type: none"> Retail health clinic On-line visit Chiropractor services <i>Limited to 30 visits per benefit period across outpatient and other professional visits.</i> 	<ul style="list-style-type: none"> \$10 copay \$10 copay \$10 copay 	<ul style="list-style-type: none"> 30% coinsurance after deductible 30% coinsurance after deductible 30% coinsurance after deductible
<p>Other services in an office:</p> <ul style="list-style-type: none"> Allergy testing Chemo/radiation therapy Hemodialysis Prescription drugs 	<ul style="list-style-type: none"> \$10 copay 20% coinsurance 20% coinsurance 20% coinsurance 	<ul style="list-style-type: none"> 30% coinsurance after deductible 30% coinsurance after deductible 30% coinsurance after deductible 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
<p>Diagnostic Services</p> <p>Lab:</p> <ul style="list-style-type: none"> Freestanding/Reference Labs Office Outpatient hospital 	<ul style="list-style-type: none"> Covered in Full 20% coinsurance 20% coinsurance 	<ul style="list-style-type: none"> 30% coinsurance after deductible 30% coinsurance after deductible 30% coinsurance after deductible
<p>X-ray:</p> <ul style="list-style-type: none"> Office Freestanding radiology center Outpatient hospital 	<ul style="list-style-type: none"> 20% coinsurance 20% coinsurance 20% coinsurance 	<ul style="list-style-type: none"> 30% coinsurance after deductible 30% coinsurance after deductible 30% coinsurance after deductible
<p>Advanced diagnostic imaging (for example, MRI/PET/CAT scans):</p> <ul style="list-style-type: none"> Office Freestanding radiology center Outpatient hospital 	<ul style="list-style-type: none"> 20% coinsurance 20% coinsurance 20% coinsurance 	<ul style="list-style-type: none"> 30% coinsurance after deductible 30% coinsurance after deductible 30% coinsurance after deductible

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Emergency and Urgent Care Urgent care (office setting) Emergency room facility services Emergency room doctor and other services Ambulance (air and ground)	\$35 copay \$200 copay 20% coinsurance 20% coinsurance	30% coinsurance after deductible Same as In Network Same as In Network Same as In Network
Outpatient Mental/Behavioral Health and Substance Abuse Doctor office visit	\$10 copay	30% coinsurance after deductible
Facility visit: Facility fees Doctor services	\$250 copay 20% coinsurance	30% coinsurance after deductible 30% coinsurance after deductible
Outpatient Surgery Facility fee: Freestanding surgical center Hospital	\$250 copay \$250 copay	30% coinsurance after deductible 30% coinsurance after deductible
Doctor services: Freestanding surgical center Hospital	20% coinsurance 20% coinsurance	30% coinsurance after deductible 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
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 <i>Limited to 100 visits per benefit period ; limit does not apply to Home Infusion Therapy or Home Dialysis. Private Duty Nursing Benefit Maximum is 16 hours per Benefit Period, In-and Out of Network combined</i>	\$10 copay	30% coinsurance after deductible
Rehabilitation services (for example, physical/speech/occupational therapy): Office Outpatient hospital <i>Limited to 30 combined visits per benefit period for Physical & Occupational Therapy. Limited to 30 visits for Speech Therapy. Limits will not apply if care is received as part of hospice or home health.</i>	\$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) <i>Limited to 100 combined days per stay In & Out of Network combined for Physical Medicine and Rehab and Skilled Nursing Facility (includes services in an Outpatient Day Rehabilitation Program).</i>	\$500 copay per 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
<p>Retail Prescription Drug Coverage <i>This plan uses a Anthem National Drug List. Drugs not on the list are not covered. Home Delivery copays are 2.5 times retail copays and select drugs are available for up to a 90 day supply.</i></p>		
<p>Drug tier 1 - Typically Generic</p>	\$5 copay	30% coinsurance
<p>Drug tier 2 - Typically Preferred / Formulary Brand</p>	\$30 copay	30% coinsurance
<p>Drug tier 3 - Typically Non-preferred/Non-formulary and Specialty Drugs</p>	\$60 copay	30% coinsurance
<p>Drug tier 4 - Typically Specialty Drugs</p>	25% coinsurance	30% coinsurance
<p>Drug tier 4 per-prescription maximum cost share</p>	\$250	None

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Covered Vision Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
<p><i>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.</i></p> <p><i>Only children's vision services count towards your out of pocket limit.</i></p>	<p><i>For children through age 18, there is a selection of frames and contact lenses that are covered under this plan. Review the formal contract of coverage or contact your vision provider for more information.</i></p>	<p><i>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.</i></p>
<p>Children's Vision Essential Health Benefits</p> <p>Vision exam</p>	<p>\$0 copay</p>	<p>\$30 reimbursement</p>
<p>Frames</p>	<p>\$0 copay</p>	<p>\$45 reimbursement</p>
<p>Lenses</p> <p>Single</p> <p>Bifocal</p> <p>Trifocal</p>	<p>\$0 copay</p> <p>\$0 copay</p> <p>\$0 copay</p>	<p>\$25 reimbursement</p> <p>\$40 reimbursement</p> <p>\$55 reimbursement</p>
<p>Elective Contact Lenses</p>	<p>\$0 copay</p>	<p>\$60 reimbursement</p>
<p>Non-Elective Contact Lenses</p>	<p>Covered in full</p>	<p>\$210 reimbursement</p>

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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 Essential Health 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
<p><i>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.</i></p>		
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 Essential Health 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

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Notes:

- 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.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- 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.
- Your copays, coinsurance and deductible count toward your out of pocket amount.
- Wigs needed after cancer treatment is limited to one wig per benefit period.
- Private Duty Nursing at home is limited to 16 hours per benefit period
- For additional information on limitations and exclusions that apply to this plan, go to sgplans.anthem.com/va/le/hk
- For additional information on this plan, please visit sbc.anthem.com to obtain a "Summary of Benefit Coverage".

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