Your summary of benefits

Anthem HealthKeepers

HealthKeepers, Inc.
Your Contract Code: 2T3V
Your Plan: Anthem HealthKeepers Gold OAPOS 2000/20%/3500

Your Network: HealthKeepers

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 HealthKeepers 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.*	$2,000 person / $4,000 family	$4,000 person / $8,000 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.*	$3,500 person / $7,000 family	$7,000 person / $14,000 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	$30 copay per visit deductible does not apply	30% coinsurance after deductible is met
Enhanced Personal Healthcare provider	$25 copay per visit deductible does not apply	30% coinsurance after deductible is met
Specialist care visit	$50 copay per visit deductible does not apply	30% coinsurance after deductible is met

Your summary of benefits

Prenatal and Post-natal Care *In-Network preventative prenatal services are covered at 100%.*	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Other practitioner visits:		
Retail health clinic	$25 copay per visit deductible does not apply	30% coinsurance after deductible is met
On-line Visit *Live Health On-Line is the preferred telehealth solutions (www.livehealthonline.com)*	$30 copay per visit deductible does not apply	30% coinsurance after deductible is met
Chiropractor services *Coverage for In-Network Provider and Non-Network Provider combined is limited to 30 visits for Rehabilitation per benefit period. Coverage for In-Network Provider and Non-Network Provider combined is limited to 30 visits for Habilitation per benefit period.*	$30 copay per visit deductible does not apply	30% coinsurance after deductible is met
Acupuncture	Not covered	Not covered
Other services in an office:		
Allergy testing	$25 copay per visit deductible does not apply	30% coinsurance after deductible is met
Chemo/radiation therapy	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Hemodialysis	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Prescription drugs *For the drugs itself dispensed in the office thru infusion/injection*	20% coinsurance after deductible is met	30% coinsurance after deductible is met

Your summary of benefits

Diagnostic Services		
Lab:		
Office	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Lab	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	30% coinsurance after deductible is met
X-ray:		
Office	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	30% coinsurance after deductible is met

Your summary of benefits

Emergency and Urgent Care		
Emergency room facility services	$300 copay per visit after deductible is met	$300 copay per visit after deductible is met
Emergency room doctor and other services	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Ambulance (air and ground)	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Urgent Care (office setting)	$60 copay per visit deductible does not apply	30% coinsurance after deductible is met
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit	$30 copay per visit deductible does not apply	30% coinsurance after deductible is met
Facility visit:		
Facility fees	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Surgery		
Facility fees:		
Hospital	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	30% coinsurance after deductible is met

Your summary of benefits

Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)		
Facility fees (for example, room & board)	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor and other services	20% 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 100 visits per benefit period. Visit limit does not apply to Home Infusion Therapy or Home Dialysis. Coverage for private duty nursing is limited to 16 hours per benefit period.*	$50 copay per visit deductible does not apply	30% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for physical therapy and occupational therapy combined is limited to 30 visits per benefit period and Speech Therapy is limited to 30 visits per benefit period. Apply to In-Network Provider and Non-Network Provider combined. Visit limit does not apply when performed as part of Hospice or Home Health. Visit limits are combined both across outpatient and other professional visits, and in and out of network.*	$30 copay per visit deductible does not apply	30% coinsurance after deductible is met
Outpatient hospital *Coverage for physical therapy and occupational therapy combined is limited to 30 visits per benefit period and Speech Therapy is limited to 30 visits per benefit period. Apply to In-Network Provider and Non-Network Provider combined. Visit limit does not apply when performed as part of Hospice or Home Health. Visit limits are combined both across outpatient and other professional visits, and in and out of network.*	20% coinsurance after deductible is met	30% coinsurance after deductible is met

Habilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for physical therapy and occupational therapy combined is limited to 30 visits per benefit period and Speech Therapy is limited to 30 visits per benefit period. Apply to In-Network Provider and Non-Network Provider combined. Visit limit does not apply when performed as part of Hospice or Home Health. Visit limits are combined both across outpatient and other professional visits, and in and out of network.*	$30 copay per visit deductible does not apply	30% coinsurance after deductible is met
Outpatient hospital *Coverage for physical therapy and occupational therapy combined is limited to 30 visits per benefit period and Speech Therapy is limited to 30 visits per benefit period. Apply to In-Network Provider and Non-Network Provider combined. Visit limit does not apply when performed as part of Hospice or Home Health. Visit limits are combined both across outpatient and other professional visits, and in and out of network.*	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Cardiac rehabilitation		
Office	$50 copay per visit deductible does not apply	30% coinsurance after deductible is met
Outpatient hospital	20% 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 100 days per admission.*	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Hospice	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Durable Medical Equipment	20% 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.*	20% 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	Not Applicable	Not Applicable
Pharmacy Out of Pocket	$3,500 person / $7,000 family	$7,000 person / $14,000 family
Prescription Drug Coverage *Anthem Select Drug List* *This product has a 90 day Retail Pharmacy Network available.*		
Other Drug Coverage		
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 with a copay for each 30 day supply.*	$10 copay per prescription deductible does not apply (retail only) and $25 copay per prescription deductible does not apply (home delivery only)	30% coinsurance
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 with a copay for each 30 day supply.*	$40 copay per prescription deductible does not apply (retail only) and $120 copay per prescription deductible does not apply (home delivery only)	30% coinsurance
Tier 3 - Typically Non-Preferred Brand and Generic drugs *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 with a copay for each 30 day supply.*	$75 copay per prescription deductible does not apply (retail only) and $225 copay per prescription deductible does not apply (home delivery only)	30% coinsurance

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Tier 4 - Typically 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: 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 with a copay for each 30 day supply. No coverage for non-formulary drugs.*	25% coinsurance up to $350 per prescription deductible does not apply (retail and home delivery)	30% coinsurance

Your summary of benefits

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. 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.		
Children's Vision Essential Health Benefits		
Child Vision Deductible	Not Applicable	Not Applicable
Vision exam *Coverage for In-Network Providers and Non-Network Providers combined is limited to 1 unit per benefit period. Limited reimbursement up to maximum allowable for out of network services*	No charge	$0 copay up to maximum allowable amount
Frames *Coverage for In-Network Providers and Non-Network Providers combined is limited to 1 unit per benefit period. Limited reimbursement up to maximum allowable for out of network services.*	No charge	$0 copay up to maximum allowable amount
Lenses *Coverage for In-Network Providers and Non-Network Providers combined is limited to 1 unit per benefit period. Limited reimbursement up to maximum allowable for out of network services.*	No charge	$0 copay up to maximum allowable amount
Elective contact lenses *Coverage for In-Network Providers and Non-Network Providers combined is limited to 1 unit per benefit period. Limited reimbursement up to maximum allowable for out of network services.*	No charge	$0 copay up to maximum allowable amount
Non-Elective Contact Lenses *Coverage for In-Network Providers and Non-Network Providers combined is limited to 1 unit per benefit period. Limited reimbursement up to maximum allowable for out of network services.*	No charge	$0 copay up to maximum allowable amount

Your summary of benefits

Adult Vision		
Adult Vision Deductible	Not Applicable	Not Applicable
Vision exam *Coverage for In-Network Providers and Non-Network Providers combined is limited to 1 exam per benefit period. Coverage for Non-Network Providers is limited to $30 maximum benefit per visit.*	$20 copay per visit	Amount above $30 reimbursement
Frames	Not covered	Not covered
Lenses	Not covered	Not covered
Elective contact lenses	Not covered	Not covered
Non-Elective Contact Lenses	Not covered	Not covered

Your summary of benefits

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. 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 dental services count towards your out of pocket limit.		
Children's Dental Essential Health Benefits Diagnostic and preventive *Coverage for In-Network Providers and Non-Network Providers combined is limited to 2 visits per 12 months.*	No charge	30% coinsurance after deductible
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	Combined with medical deductible	Combined with medical deductible
Adult Dental		
Diagnostic and preventive	Not covered	Not covered
Basic services	Not covered	Not covered
Major services	Not covered	Not covered
Deductible	Not Applicable	Not Applicable
Annual maximum	$0	$0

Your summary of benefits

Your plan also includes the following health and wellness incentive rewards		
Health assessment	Members are rewarded for completing online health assessment.	$50 / year gift card
Tobacco free certification	By certifying online, members are rewarded for being tobacco free.	$50 / year gift card
Adult wellness exam and annual flu shot	Members are rewarded for getting their annual adult wellness exam and annual flu shot. Members must complete both the wellness exam ($50) and the flu shot ($50) to receive $100 in rewards. Activities can be completed in any order. Once the second of the two activities is complete, two $50 rewards will be given.	$100 / year in gift cards

Your summary of benefits

Notes:

- Your copays, coinsurance and deductible count toward your out of pocket amount
- 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.
- Covered out-of-network Human Organ and Tissue Transplant services do not apply toward the out-of-pocket limit
- 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.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.
- To view your prescription formulary list log on to www.anthem.com/health-insurance/customer-care/forms-library.
- 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 this plan, please visit sbc.anthem.com to obtain a "Summary of Benefit Coverage".
- For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to sgplans.anthem.com/va/le/bcbs

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 (855) 330-1214.

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 330-1214 (855).

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՝ (855) 330-1214:

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 (855) 330-1214。

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 330-1214 (855) 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 (855) 330-1214.

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 (855) 330-1214.

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 (855) 330-1214.

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、(855) 330-1214 にお電話ください。

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (855) 330-1214 로 문의하십시오.

Navajo (Diné): Díí naaltsoos bíká'ígíí łahgo bína'ídíłkidgo 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 nínízingo kojį' hodíílnih (855) 330-1214.

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: (855) 330-1214.

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, (855) 330-1214 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. (855) 330-1214.

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 (855) 330-1214.

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 (855) 330-1214.

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 (855) 330-1214.

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.