Your summary of benefits

Anthem HealthKeepers

Anthem® HealthKeepers Inc.

Your Contract Code: 5L89

Your Plan: Anthem HealthKeepers Silver OAPOS 6850/0%/6850 w/HSA

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.*	$6,850 person / $13,700 family	$17,125 person / $34,250 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.*	$6,850 person / $13,700 family	$20,550 person / $41,100 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 Office Visit to treat an injury or illness	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Specialist Care Office Visit and Online Visit	0% 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
Prenatal and Post-natal Care *In-Network preventive prenatal services are covered at 100%.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	0% coinsurance after deductible is met	30% coinsurance after deductible is met
On-line Visit *Includes Mental Health and Substance Use Disorder* *Live Health Online is the preferred telehealth solution.* *(www.livehealthonline.com).*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Chiropractic Services *Coverage for Rehabilitation and Habilitation is limited to 30 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Acupuncture	Not covered	Not covered
Other Services in an Office:		
Allergy Testing	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Radiation/Chemotherapy/Non Preventive Infusion & Injection	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Hemodialysis	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Prescription Drugs *For the drugs itself dispensed in the office through infusion/injection.*	0% 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
Diagnostic Services		
Lab:		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Preferred Reference Lab	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
X-Ray:		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Radiology Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Radiology Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% 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
Emergency and Urgent Care		
Urgent Care Center Office Visit	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Emergency Room Facility Services	0% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	0% coinsurance after deductible is met	Covered as In-Network
Ambulance Transportation	0% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder		
Doctor Office Visit	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Facility visit:		
Facility Fees	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor Services	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Surgical Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor and Other Services:		

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Surgical Center	0% 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) *Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 100 days combined per admission. Limit is combined In-Network and Non-Network.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor and other services	0% 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
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 100 visits per benefit period. Private Duty Nursing included with Home Health Care is limited to 16 hours per benefit period. Limit is combined In-Network and Non-Network. Visit limit does not apply to Home Infusion Therapy or Home Dialysis.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for Physical Therapy and Occupational Therapy is limited to 30 visits combined per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings. Coverage for Speech Therapy is limited to 30 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings. Benefit limit does not apply to Applied Behavioral Analysis. Visit limit does not apply when performed as part of Early Intervention or Hospice. When rendered in the home, the Home Care visit limit applies instead of the Therapy Services limits.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital *Coverage for Physical Therapy and Occupational Therapy is limited to 30 visits combined per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings. Coverage for Speech Therapy is limited to 30 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings. Visit limit does not apply when performed as part of Early Intervention or Hospice. When rendered in the home, the Home Care visit limit applies instead of the Therapy Services limits. Benefit limit does not apply to Applied Behavioral Analysis.*	0% 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 is limited to 30 visits combined per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings. Coverage for Speech Therapy is limited to 30 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings. Benefit limit does not apply to Applied Behavioral Analysis.*	0% 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
Outpatient Hospital *Coverage for Physical Therapy and Occupational Therapy is limited to 30 visits combined per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings. Coverage for Speech Therapy is limited to 30 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings. Benefit limit does not apply to Applied Behavioral Analysis.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Cardiac rehabilitation		
Office Visit	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% 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 is limited to 100 days combined per admission. Limit is combined In-Network and Non-Network.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Hospice	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Durable Medical Equipment	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs after cancer treatment is limited to 1 item per benefit period. Limit is combined In-Network and Non-Network.*	0% 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 maximum	Combined with medical out of pocket maximum
Prescription Drug Coverage *Select Drug List* *This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.*		
Preventive Drugs *Preventive Rx Plus: Deductible is waived for certain drugs for diabetes, asthma, heart health, high blood pressure, high cholesterol, stroke, and osteoporosis. The medications are also available through the same Home Delivery program as regular Tier 1 and Tier 2 drugs. This plan has Preventive RX coverage that allows the cost share without application to Deductible for designated Preventive drugs.*		
Tier 1 - Typically Generic	20% coinsurance per prescription, deductible does not apply (retail only)	Not covered (retail and home delivery)
Tier 2 - Typically Preferred Brand	20% coinsurance per prescription, deductible does not apply (retail only)	Not covered (retail and home delivery)
Tier 1 - Typically Generic *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs. Coverage is also provided for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time.*	0% coinsurance after deductible is met (retail and home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs. Coverage is also provided for*	0% coinsurance after deductible is met (retail and home delivery)	30% coinsurance after deductible is met (retail) and Not

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time.		covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs. Coverage is also provided for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time.*	0% coinsurance after deductible is met (retail and home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) *Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program). No coverage for non-formulary drugs.*	0% coinsurance after deductible is met (retail and home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)

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. Benefits include coverage for member's choice of eyeglass lenses or contact lenses, but not both. 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 (up to age 19)		
Child Vision Deductible	Not Applicable	Not Applicable
Vision exam *Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Frames *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Single Vision Lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Bifocal Vision Lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Trifocal Vision Lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Elective contact lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Non-Elective Contact Lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Adult Vision (age 19 and older)		
Adult Vision Deductible	Not Applicable	Not Applicable

Your summary of benefits

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Vision exam *Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.*	$20 copay	Reimbursed Up to $30
Frames	Not covered	Not covered
Single Vision Lenses	Not covered	Not covered
Bifocal Vision Lenses	Not covered	Not covered
Trifocal Vision 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.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Basic services	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Major services	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Medically Necessary Orthodontia services	0% coinsurance after deductible is met	50% coinsurance after deductible is met
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 covered	Not covered
Annual maximum	Not covered	Not covered

Your summary of benefits

Your plan also includes the following Healthy Support & Rewards features. *To see your rewards and additional information log into the Anthem website at anthem.com or call the customer service number on your member ID card.*		
My Health Rewards	Subscriber and spouse/domestic partner may earn rewards for participating in this program. If you participate, you will earn points by completing designated activities and milestones. The points will be redeemed for rewards. At each of the three milestones, the member can earn $50.	Up to $150 per member per year.
Processed Claim: Adult Wellness Exam	Subscriber and spouse/domestic partner may earn a reward if you complete an annual preventive wellness exam and it is verified by an Anthem claim. This activity requires completion of the Annual Flu Shot in order to earn the rewards.	Up to $25 per member per year.
Processed Claim: Annual Flu Shot	Subscriber and spouse/domestic partner may earn a reward if you get your annual flu shot and it is verified by an Anthem claim. This activity requires completion of the Adult Wellness Exam in order to earn the rewards.	Up to $25 per member per year.

Your summary of benefits

Notes:

- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both 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.
- For additional information on this plan, please visit www.sbc.anthem.com to obtain a "Summary of Benefits and Coverage".
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- Your copays, coinsurance and deductible count toward your out of pocket amount.

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 (855) 330-1214 .

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 (855) 330-1214 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 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(855) 330-1214로 문의하십시오.

Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'idiłkidgo 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 ninízingo kojį' hodíilnih (855) 330-1214.

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.