

Your summary of benefits



Anthem HealthKeepers

HealthKeepers, Inc.

Your Plan: Anthem HealthKeepers Gold OAPOS 25/20%/4500

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 <i>See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.</i>	Not Applicable	\$2,000 person / \$4,000 family
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 for additional information regarding your out of pocket maximum.</i>	\$4,500 person / \$9,000 family	\$9,000 person / \$18,000 family
Preventive care/screening/immunization <i>In-network preventive care is not subject to deductible, if your plan has a deductible.</i>	No charge	30% coinsurance after deductible is met
Doctor Home and Office Services		
Primary care visit to treat an injury or illness	\$25 copay per visit deductible does not apply	30% coinsurance after deductible is met
Enhanced Personal Healthcare provider	\$15 copay per visit deductible does not apply	30% coinsurance after deductible is met
Specialist care visit	\$60 copay per visit deductible does not apply	30% coinsurance after deductible is met

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Prenatal and Post-natal Care	\$300 copay per pregnancy deductible does not apply	30% coinsurance after deductible is met
Other practitioner visits: Retail health clinic On-line Visit Chiropractor services <i>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.</i> Acupuncture	\$15 copay per visit deductible does not apply \$25 copay per visit deductible does not apply \$25 copay per visit deductible does not apply Not covered	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met Not covered
Other services in an office: Allergy testing Chemo/radiation therapy Hemodialysis Prescription drugs <i>For the drugs itself dispensed in the office thru infusion/injection</i>	\$15 copay per visit deductible does not apply 20% coinsurance deductible does not apply 20% coinsurance deductible does not apply 20% coinsurance deductible does not apply	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met

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<p>Diagnostic Services</p> <p>Lab:</p> <p>Office</p> <p>Freestanding Lab</p> <p>Outpatient Hospital</p>	<p>20% coinsurance deductible does not apply</p> <p>No charge</p> <p>\$300 copay per visit deductible does not apply</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p>X-ray:</p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>20% coinsurance deductible does not apply</p> <p>\$300 copay per visit deductible does not apply</p> <p>\$300 copay per visit deductible does not apply</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p>Advanced diagnostic imaging (for example, MRI/PET/CAT scans):</p> <p>Office <i>Copay is applied in addition to any other services rendered on the same day by the same providers</i></p> <p>Freestanding Radiology Center <i>Copay is applied in addition to any other services rendered on the same day by the same providers</i></p> <p>Outpatient Hospital <i>Copay is applied in addition to any other services rendered on the same day by the same providers</i></p>	<p>\$60 copay per visit deductible does not apply</p> <p>\$150 copay per visit deductible does not apply</p> <p>\$150 copay per visit deductible does not apply</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>

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<p>Emergency and Urgent Care</p> <p>Emergency room facility services <i>Copay waived if admitted.</i></p> <p>Emergency room doctor and other services</p>	<p>\$350 copay per visit deductible does not apply</p> <p>20% coinsurance deductible does not apply</p>	<p>\$350 copay per visit deductible does not apply</p> <p>20% coinsurance deductible does not apply</p>
<p>Ambulance (air and ground)</p>	<p>20% coinsurance deductible does not apply</p>	<p>20% coinsurance deductible does not apply</p>
<p>Urgent Care (office setting)</p>	<p>\$60 copay per visit deductible does not apply</p>	<p>30% coinsurance after deductible is met</p>
<p>Outpatient Mental/Behavioral Health and Substance Abuse</p> <p>Doctor office visit</p> <p>Facility visit: Facility fees</p>	<p>\$25 copay per visit deductible does not apply</p> <p>\$300 copay per visit deductible does not apply</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p>Outpatient Surgery</p> <p>Facility fees:</p> <p>Hospital</p> <p>Freestanding Surgical Center</p> <p>Doctor and other services</p>	<p>\$300 copay per visit deductible does not apply</p> <p>\$300 copay per visit deductible does not apply</p> <p>20% coinsurance deductible does not apply</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>

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<p>Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)</p> <p>Facility fees (for example, room & board) <i>Coverage for In-Network Providers is limited to 3 days per admission. Coverage for Inpatient rehabilitation and skilled nursing services combined In-Network Provider and Non-Network Provider combined is limited to 100 days per admission.</i></p> <p>Doctor and other services</p>	<p>\$500 copay per day deductible does not apply</p> <p>20% coinsurance deductible does not apply</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p>Recovery & Rehabilitation</p> <p>Home health care <i>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.</i></p>	<p>\$60 copay per visit deductible does not apply</p>	<p>30% coinsurance after deductible is met</p>
<p>Rehabilitation services (for example, physical/speech/occupational therapy):</p> <p>Office <i>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.</i></p> <p>Outpatient hospital <i>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.</i></p>	<p>\$25 copay per visit deductible does not apply</p> <p>20% coinsurance deductible does not apply</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>

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<p>Habilitation services (for example, physical/speech/occupational therapy):</p> <p>Office <i>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.</i></p> <p>Outpatient hospital <i>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.</i></p>	<p>\$25 copay per visit deductible does not apply</p> <p>20% coinsurance deductible does not apply</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p>Cardiac rehabilitation</p> <p>Office</p> <p>Outpatient hospital</p>	<p>\$60 copay per visit deductible does not apply</p> <p>20% coinsurance deductible does not apply</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p>Skilled nursing care (in a facility) <i>Coverage for In-Network Providers is limited to 3 days per admission. Coverage for Inpatient rehabilitation and skilled nursing services combined In-Network Provider and Non-Network Provider combined is limited to 100 days per admission.</i></p>	<p>\$500 copay per day deductible does not apply</p>	<p>30% coinsurance after deductible is met</p>
<p>Hospice</p>	<p>No charge</p>	<p>30% coinsurance after deductible is met</p>
<p>Durable Medical Equipment</p>	<p>20% coinsurance deductible does not apply</p>	<p>30% coinsurance after deductible is met</p>
<p>Prosthetic Devices <i>Coverage for wigs needed after cancer treatment In-Network and Non-Network Provider combined is limited to 1 unit per benefit period.</i></p>	<p>20% coinsurance deductible does not apply</p>	<p>30% coinsurance after deductible is met</p>

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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	Combined with medical out of pocket	Combined with medical out of pocket
Prescription Drug Coverage <i>Anthem National Drug List 4 Tier</i>		
Tier 1 - Typically Generic <i>Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs.</i>	\$15 copay per prescription deductible does not apply (retail only) and \$38 copay per prescription deductible does not apply (home delivery only)	30% coinsurance after deductible is met
Tier 2 - Typically Preferred Brand & Non-Preferred Generics <i>Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.</i>	\$40 copay per prescription deductible does not apply (retail only) and \$120 copay per prescription deductible does not apply (home delivery only)	30% coinsurance after deductible is met
Tier 3 - Typically Non-Preferred Brand and Generic drugs <i>Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.</i>	\$80 copay per prescription deductible does not apply (retail only) and \$240 copay per prescription deductible does not apply (home delivery only)	30% coinsurance after deductible is met
Tier 4 - Typically Specialty (brand and generic) <i>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. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.</i>	25% coinsurance up to \$300 per prescription deductible does not apply (retail and home delivery)	30% coinsurance after deductible is met

Your summary of benefits

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. 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.</i></p>		
<p>Children's Vision Essential Health Benefits</p> <p>Child Vision Deductible</p> <p>Vision exam <i>Coverage for In-Network Provider and Non-Network Provider combined is limited to 1 exam per benefit period. Limited reimbursement up to maximum allowable for out of network services</i></p>	<p>Not Applicable No charge</p>	<p>Not Applicable No charge</p>
<p>Frames <i>Coverage for In-Network Provider and Non-Network Provider combined is limited to 1 unit per benefit period. Limited reimbursement up to maximum allowable for out of network services</i></p>	<p>No charge</p>	<p>No charge</p>
<p>Lenses <i>Coverage for In-Network Provider and Non-Network Provider combined is limited to 1 unit per benefit period. Limited reimbursement up to maximum allowable for out of network services</i></p>	<p>No charge</p>	<p>No charge</p>
<p>Elective contact lenses <i>Coverage for In-Network Provider and Non-Network Provider combined is limited to 1 unit per benefit period. Limited reimbursement up to maximum allowable for out of network services</i></p>	<p>No charge</p>	<p>No charge</p>
<p>Non-Elective Contact Lenses <i>Coverage for In-Network Provider and Non-Network Provider combined is limited to 1 unit per benefit period. Limited reimbursement up to maximum allowable for out of network services</i></p>	<p>No charge</p>	<p>No charge</p>
<p>Adult Vision</p> <p>Adult Vision Deductible</p> <p>Vision exam <i>Coverage for In-Network Provider and Non-Network Provider combined is limited to 1 exam per benefit period. Coverage for Non-Network Providers is limited to \$30 maximum benefit per visit.</i></p>	<p>\$0 person \$20 copay per visit</p>	<p>\$0 person No charge</p>

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Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
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
<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.</i></p> <p><i>Only children's dental services count towards your out of pocket limit.</i></p>		
<p>Children's Dental Essential Health Benefits Diagnostic and preventive <i>Coverage for In-Network Provider and Non-Network Provider combined is limited to 2 visits per 12 months.</i></p>	No charge	30% coinsurance
<p>Basic services</p>	40% coinsurance	50% coinsurance
<p>Major services</p>	50% coinsurance	50% coinsurance
<p>Medical Necessary Orthodontia services</p>	50% coinsurance	50% coinsurance
<p>Cosmetic Orthodontia services</p>	Not covered	Not covered
<p>Deductible</p>	Combined with medical deductible	Combined with medical deductible
<p>Adult Dental</p>		
<p>Diagnostic and preventive</p>	Not covered	Not covered
<p>Basic services</p>	Not covered	Not covered
<p>Major services</p>	Not covered	Not covered
<p>Deductible</p>	\$0	\$0
<p>Annual maximum</p>	Not Applicable	Not Applicable

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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

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Notes:

- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- 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
- All medical services subject to a coinsurance are also subject to the annual medical deductible.
- 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/bcb.