Your summary of benefits

Anthem HealthKeepers

HealthKeepers, Inc.

Your Plan: Anthem HealthKeepers Silver OAPOS 4000/20%/6850

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.*	$4,000 person / $8,000 family	$8,000 person / $16,000 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.*	$6,850 person / $13,700 family	$13,700 person / $27,400 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	$40 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	$60 copay per visit deductible does not apply	30% coinsurance after deductible is met

Your summary of benefits

Prenatal and Post-natal Care	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	$40 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.*	$40 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	No charge	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

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Emergency and Urgent Care		
Emergency room facility services *Copay waived if admitted.*	$300 copay per visit deductible does not apply	$300 copay per visit deductible does not apply
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	$40 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) *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
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.*	$60 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.*	$40 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.*	$40 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	$60 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	0% 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
Prosthetics 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

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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	$250 person/$500 family	$250 person/$500 family
Pharmacy Out of Pocket	Combined with medical out of pocket	Combined with medical out of pocket
Prescription Drug Coverage *Anthem National Drug List 4 Tier*		
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 90 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs.*	$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 *Covers up to a 90 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.*	$40 copay per prescription after deductible is met (retail only) and $120 copay per prescription after deductible is met (home delivery only)	30% coinsurance after deductible is met
Tier 3 - Typically Non-Preferred Brand and Generic drugs *Covers up to a 90 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.*	$80 copay per prescription after deductible is met (retail only) and $240 copay per prescription after deductible is met (home delivery only)	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
Tier 4 - Typically Specialty (brand and generic) *Covers up to a 90 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.*	25% coinsurance up to $300 after deductible is met (retail and home delivery)	30% coinsurance after deductible is met

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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 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*	No charge	No charge
Frames *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*	No charge	No charge
Lenses *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*	No charge	No charge
Elective contact lenses *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*	No charge	No charge
Non-Elective Contact Lenses *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*	No charge	No charge
Adult Vision		
Adult Vision Deductible	$0 person	$0 person
Vision exam *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.*	$20 copay per visit	No charge

Your summary of benefits

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
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 Provider and Non-Network Provider combined is limited to 2 visits per 12 months.*	No charge	30% coinsurance
Basic services	40% coinsurance	50% coinsurance
Major services	50% coinsurance	50% coinsurance
Medical Necessary Orthodontia services	50% coinsurance	50% coinsurance
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	$0	$0
Annual maximum	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/bcbs