

Your summary of benefits



Anthem. HealthKeepers

HealthKeepers, Inc.

Your Contract Code: 4JT2

Your Plan: Anthem HealthKeepers POS OA 25/30%/5000 Rx \$15/\$50/\$85/20%

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>	\$0 person / \$0 family	\$1,000 person / \$2,000 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>	\$5,000 person / \$10,000 family	\$12,500 person / \$25,000 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 medical deductible is met
Doctor Home and Office Services Primary Care Visit to treat an injury or illness	\$25 copay per visit	30% coinsurance after medical deductible is met
Specialist Care Visit	\$50 copay per visit	30% coinsurance after medical deductible is met

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<p>Prenatal and Post-natal Care <i>In-Network preventive prenatal services are covered at 100%.</i></p>	\$350 copay per pregnancy	30% coinsurance after medical deductible is met
<p>Other Practitioner Visits:</p> <p>Retail Health Clinic</p> <p>Preferred On-line Visit <i>Includes Mental Health and Substance Use Disorder Live Health Online is the preferred telehealth solution. www.livehealthonline.com.</i></p> <p>Other Participating Provider On-line Visit <i>Includes Mental Health and Substance Use Disorder</i></p> <p>Chiropractic Services <i>Coverage for Rehabilitation and Habilitation is limited to 30 visits combined per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.</i></p>	<p>\$25 copay per visit</p> <p>\$15 copay per visit</p> <p>\$25 copay per visit</p> <p>\$25 copay per visit</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>
<p>Other Services in an Office:</p> <p>Allergy Testing</p> <p>Chemo/Radiation Therapy</p> <p>Hemodialysis</p> <p>Prescription Drugs <i>For the drugs itself dispensed in the office through infusion/injection.</i></p>	<p>\$25 copay per visit</p> <p>30% coinsurance</p> <p>30% coinsurance</p> <p>30% coinsurance</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>

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<p>Diagnostic Services</p> <p>Lab:</p> <p>Office</p> <p>Preferred Reference Lab</p> <p>Outpatient Hospital</p>	<p>No charge</p> <p>No charge</p> <p>\$350 copay per visit</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>
<p>X-Ray:</p> <p>Office</p> <p>Outpatient Hospital</p>	<p>30% coinsurance</p> <p>\$350 copay per visit</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>
<p>Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):</p> <p>Office</p> <p>Outpatient Hospital</p>	<p>30% coinsurance</p> <p>\$350 copay per visit</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>

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Emergency and Urgent Care Urgent Care Center Office Visit	\$50 copay per visit	30% coinsurance after medical deductible is met
Emergency Room Facility Services <i>Copay waived if admitted.</i>	\$350 copay per visit	Covered as In-Network
Emergency Room Doctor and Other Services	30% coinsurance	Covered as In-Network
Emergency Room Mental Health and Substance Use Disorder Doctor Services	\$25 copay per visit	Covered as In-Network
Ambulance Transportation	30% coinsurance	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Doctor Office Visit	\$25 copay per visit	30% coinsurance after medical deductible is met
Facility visit: Facility Fees	\$350 copay per visit	30% coinsurance after medical deductible is met
Doctor Services	\$25 copay per visit	30% coinsurance after medical 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
<p>Outpatient Surgery</p> <p>Facility Fees:</p> <p style="padding-left: 20px;">Hospital</p> <p style="padding-left: 20px;">Freestanding Surgical Center</p> <p>Doctor and Other Services:</p> <p style="padding-left: 20px;">Hospital</p>	<p>\$350 copay per visit</p> <p>\$350 copay per visit</p> <p>\$50 copay per visit</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>
<p>Hospital Stay (all Inpatient stays including Maternity, Mental and Substance Use Disorder):</p> <p>Facility fees (for example, room & board) <i>Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 150 days combined per benefit period. Limit is combined In-Network and Non-Network.</i></p> <p>Doctor and other services</p>	<p>\$350 copay per day to a maximum of \$1,750 per admission</p> <p>\$50 copay per visit</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Recovery & Rehabilitation</p> <p>Home Health Care <i>Coverage is limited to 100 visits per benefit period. Limit is combined In-Network and Non-Network. Limits are combined for home health care and private duty nursing.</i></p>	30% coinsurance	30% coinsurance after medical deductible is met
<p>Rehabilitation services (for example, physical/speech/occupational therapy):</p> <p>Office <i>Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.</i></p> <p>Outpatient Hospital <i>Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.</i></p>	<p>\$25 copay per visit</p> <p>30% coinsurance</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>
<p>Habilitation services (for example, physical/speech/occupational therapy):</p> <p>Office <i>Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Limit is combined across professional visits and outpatient facilities. Limit is combined for In-Network and Non-Network. Visit limit does not apply when performed as part of Hospice, Home Health, Early Intervention or Autism service.</i></p>	\$25 copay per visit	30% coinsurance after medical 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
<p>Outpatient Hospital <i>Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits combined per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Limit is combined across professional visits and outpatient facilities. Limit is combined for In-Network and Non-Network. Visit limit does not apply when performed as part of Hospice, Home Health, Early Intervention or Autism service.</i></p>	30% coinsurance	30% coinsurance after medical deductible is met
<p>Cardiac rehabilitation</p> <p>Office Visit <i>Coverage for cardiac rehabilitation is limited to 36 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.</i></p> <p>Outpatient Hospital <i>Coverage for cardiac rehabilitation is limited to 36 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.</i></p>	\$50 copay per visit 30% coinsurance	30% coinsurance after medical deductible is met 30% coinsurance after medical deductible is met
<p>Skilled Nursing Care (in a facility) <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period. Limit is combined In-Network and Non-Network.</i></p>	\$350 copay per day to a maximum of \$1,750 per admission	30% coinsurance after medical deductible is met
<p>Hospice</p>	30% coinsurance	30% coinsurance after medical deductible is met
<p>Durable Medical Equipment</p>	30% coinsurance	30% coinsurance after medical deductible is met
<p>Prosthetic Devices <i>Coverage for wigs needed after cancer treatment is limited to 1 item per benefit period. Limit is combined In-Network and Non-Network.</i></p>	30% coinsurance	30% coinsurance after medical 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	Combined with medical out of pocket maximum	Combined with medical out of pocket maximum
Prescription Drug Coverage <i>Essential Drug List</i> <i>This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.</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). 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.</i>	\$15 copay per prescription, deductible does not apply (retail) and \$38 copay per prescription, deductible does not apply (home delivery)	30% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand <i>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.</i>	\$50 copay per prescription, deductible does not apply (retail) and \$125 copay per prescription, deductible does not apply (home delivery)	30% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand <i>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.</i>	\$85 copay per prescription, deductible does not apply (retail) and \$213 copay per prescription, deductible does not	30% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
	apply (home delivery)	
<p>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. 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.</i></p>	20% coinsurance up to \$250 per prescription, deductible does not apply (retail and home delivery)	30% coinsurance, deductible does not apply (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
<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>Child Vision exam <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.</i></p>	No charge	Reimbursed Up to \$30
<p>Adult Vision exam <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.</i></p>	\$15 copay	Reimbursed Up to \$30

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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.
- All medical services subject to a coinsurance are also subject to the annual medical deductible, if deductible is applicable to plan.
- 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 and you use a non-participating provider, you are responsible for any difference between the covered expense and the actual non-participating provider's charge.
- To view your prescription formulary list log on to www.anthem.com/health-insurance/customer-care/forms-library
- In-network preventive care is not subject to deductible, if you plan has a deductible.
- This plan includes Home Delivery (Mail Order). Home Delivery copays are different than the Retail Pharmacy Copays.
- 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 provider's charge. 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 www.sbc.anthem.com to obtain a "Summary of Benefits and Coverage".
- The representations of benefits in this document are subject to Division of Insurance approval and are subject to change.
- 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.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.

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 (833) 592-9956

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 (833) 592-9956.

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՝ (833) 592-9956:

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(833) 592-9956。

Farsi (فارسی): 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 شفاف، با شماره (833) 592-9956 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 (833) 592-9956.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nempòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (833) 592-9956.

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 (833) 592-9956.

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、(833) 592-9956 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(833) 592-9956로 문의하십시오.

Language Access Services:

Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'idiikidgo ná bohónéedzǎ dóó bee ahóót'i' t'áá ni nizaad k'ehǫ́ bee nił hodoonih t'áadoo bááh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih ninizingo kojí' hodíílnih (833) 592-9956.

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: (833) 592-9956.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (833) 592-9956 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. (833) 592-9956.

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 (833) 592-9956.

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 (833) 592-9956.

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 (833) 592-9956.

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>.