HealthKeepers
Anthem HealthKeepers Value Advantage 30/2000/30 POS Open Access / $10/$30/$50/20% with $150 Ded

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 06/01/2015 - 05/31/2016

Coverage For: Individual/Family | **Plan Type:** POS

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-855-333-5735.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2000** single / **$4000** family for In-Plan Provider **$3500** single / **$7000** family for Out-of-Plan Provider Does not apply to Prescription Drugs, In-Plan Preventive Care, Copayments, Hospice, Manipulative Services, Office Based Lab and Routine Eye Exam.. In-Plan Provider and Out-of-Plan Provider deductibles are separate and do not count towards each other.	You must pay all the costs up to the **deductible** amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the **deductible** starts over (usually, but not always, January 1st.) See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	Yes; **$150** per person / **$300** per family for Prescription Drug.	You must pay all the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes; In-Plan Provider Single: **$6000**, Family: **$12000** Out-of-Plan Provider Single: **$8500**, Family: **$17000**	The **out-of-pocket limit** is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for health care expenses.

Important Questions	Answers	Why this Matters:
What is not included in the out-of-pocket limit?	Balance-Billed Charges, Pre-Authorization Penalties, Health Care This Plan Doesn't Cover, Premiums, Out-of-Pocket Limit does not include Adult Routine Vision Care.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the insurer pays?	No. This policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 3 describes any limits on what the insurer will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.anthem.com** or call **1-855-333-5735** for a list of participating providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Plans use the terms in-network, preferred, or participating to refer to providers in their network.
Do I need a referral to see a specialist?	No, you do not need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 8. See your policy or plan document for additional information about excluded services.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **In-Network** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a In-Plan Provider	Your Cost If You Use a Out-of-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay	30% coinsurance	————none————
	Specialist visit	$50 copay	30% coinsurance	————none————
	Other practitioner office visit	Manipulative Therapy $25 copay Acupuncture Not covered	Manipulative Therapy 30% coinsurance Acupuncture Not covered	Manipulative Therapy Coverage is limited to 30 visits per yearper member. Failure to obtain preauthorization may result in non-coverage or reduced coverage. Services must be received by provider that participates in the American Specialty Health Network (ASHN).
	Preventive care/screening/ immunizations	No cost share	30% coinsurance	————none————
If you have a test	Diagnostic test (x-ray, blood work)	Lab - Office 30% coinsurance X-Ray - Office 30% coinsurance	Lab - Office 30% coinsurance X-Ray - Office 30% coinsurance	Lab - Office Copay does not apply when services are provided by the same provider on the same day as the office visit. A Specialist copay may apply.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	30% coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced coverage.

Common Medical Event	Services You May Need	Your Cost If You Use a In-Plan Provider	Your Cost If You Use a Out-of-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.anthem.com/pharmacyinformation/	Tier 1 – Typically Generic	$10 copay/ prescription (retail only) and $25 copay/prescription (mail order only)	$10 copay/ prescription (retail only) and $25 copay/prescription (mail order only)	Using a Non-Network provider may result in increased cost sharing. Covers up to a 30 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)
	Tier 2 – Typically Preferred/Formulary Brand	$30 copay/ prescription (retail only) and $75 copay/prescription (mail order only)	$30 copay/ prescription (retail only) and $75 copay/prescription (mail order only)	Additional deductible of $150 applies. If the member selects a brand drug when a generic equivalent is available the member is responsible for the generic copay plus the cost difference between the generic and brand equivalent even if the physician indicates no substitutions. Using a Non-Network provider may result in increased cost sharing. Covers up to a 30 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)
	Tier 3 – Typically Non-preferred/ non-Formulary Drugs	$50 copay/ prescription (retail only) and $125 copay/prescription (mail order only)	$50 copay/ prescription (retail only) and $125 copay/prescription (mail order only)	Additional deductible of $150 applies. If the member selects a brand drug when a generic equivalent is available the member is responsible for the generic copay plus the cost difference between the generic and brand equivalent even if the physician indicates no substitutions. Using a Non-Network provider may result in increased cost sharing. Covers up to a 30 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)

Common Medical Event	Services You May Need	Your Cost If You Use a In-Plan Provider	Your Cost If You Use a Out-of-Plan Provider	Limitations & Exceptions
	Tier 4 – Typically Specialty Drugs	20% coinsurance (retail only) with $200 max and 20% coinsurance (mail order only) with $400 max	20% coinsurance (retail and mail order)	Additional deductible of $150 applies. If the member selects a brand drug when a generic equivalent is available the member is responsible for the generic copay plus the cost difference between the generic and brand equivalent even if the physician indicates no substitutions. Using a Non-Network provider may result in increased cost sharing. Covers up to a 30 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)
If you have outpatient Surgery	Facility Fee (e.g., ambulatory surgery center)	30% coinsurance	30% coinsurance	————none————
	Physician/Surgeon Fees	30% coinsurance	30% coinsurance	————none————
If you need immediate medical attention	Emergency Room Services	30% coinsurance	30% coinsurance	No coverage for non emergency use of emergency room.
	Emergency Medical Transportation	30% coinsurance	30% coinsurance	————none————
	Urgent Care	$30 copay	30% coinsurance	There may be other levels of cost share that are contingent on how services are provided, please see your formal contract of coverage for a complete explanation.
If you have a hospital stay	Facility Fee (e.g., hospital room)	30% coinsurance	30% coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Physician/surgeon fee	30% coinsurance	30% coinsurance	————none————

Common Medical Event	Services You May Need	Your Cost If You Use a In-Plan Provider	Your Cost If You Use a Out-of-Plan Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit $30 copay Mental/Behavioral Health Facility Visit - Facility Charges 30% coinsurance	Mental/Behavioral Health Office Visit 30% coinsurance Mental/Behavioral Health Facility Visit - Facility Charges 30% coinsurance	————none————
	Mental/Behavioral health inpatient services	30% coinsurance	30% coinsurance	————none————
	Substance use disorder outpatient services	Substance Abuse Office Visit $30 copay Substance Abuse Facility Visit - Facility Charges 30% coinsurance	Substance Abuse Office Visit 30% coinsurance Substance Abuse Facility Visit - Facility Charges 30% coinsurance	————none————
	Substance use disorder inpatient services	30% coinsurance	30% coinsurance	————none————
If you are pregnant	Prenatal and postnatal care	30% coinsurance	30% coinsurance	Your doctor's charges for delivery are part of prenatal and postnatal care.
	Delivery and all inpatient services	30% coinsurance	30% coinsurance	————none————
If you need help recovering or have other special health needs	Home Health Care	30% coinsurance	30% coinsurance	Coverage is limited to 100 visits per year.

Common Medical Event	Services You May Need	Your Cost If You Use a In-Plan Provider	Your Cost If You Use a Out-of-Plan Provider	Limitations & Exceptions
	Rehabilitation Services	30% coinsurance	30% coinsurance	Coverage is limited to 30 visits per year for physical therapy and occupational therapy combined, 30 visits per year for speech therapy. Limit does not apply to autism services, if applicable. Services from In-Plan Provider and Out-of-Plan Provider count towards your limit.
	Habilitation Services	30% coinsurance	30% coinsurance	Rehabilitation and Habilitation visits count towards your Rehabilitation limit.
	Skilled Nursing Care	30% coinsurance	30% coinsurance	Coverage is limited to 100 days per stay. Services from In-Plan Provider and Out-of-Plan Provider count towards your limit.
	Durable medical equipment	30% coinsurance	30% coinsurance	————none————
	Hospice service	No cost share	30% coinsurance	————none————
If your child needs dental or eye care	Eye exam	$15 copay	See Limitations and Exclusions	Coverage is limited to 1 occurrence per benefit period. If you use an Out-of-plan provider, the first $30 will be covered in full. After $30, you will pay 100% of the cost.
	Glasses	See Limitations and Exclusions	Not covered	Discounts on eyewear and lenses available at participating providers.
	Dental check-up	Not covered	Not covered	————none————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Infertility treatment
- Long- term care
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide.
- Private-duty nursing
- Routine foot care Unless you have been diagnosed with diabetes. Consult your formal contract of coverage.
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Routine eye care (adult) Coverage is limited to 1 screening exam. Consult your formal contract of coverage.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-333-5735. You may also contact your state insurance department, the Department of Labor's Employee Benefits
Security Administration
1-866-444-EBSA (3272)
www.dol.gov/ebsa/healthreform.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

HealthKeepers
ATTN: Appeals
P.O. Box 27401
Richmond, VA 23279

Or Contact:

Department of Labor's Employee Benefits
Security Administration at
1-866-444-EBSA(3272) or
www.dol.gov/ebsa/healthreform

Virginia Bureau of Insurance
1300 East Main Street
P. O. Box 1157
Richmond, VA 23218
800-552-7945

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as minimum essential coverage. This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíiłkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

About These Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $3,790
- **Patient pays:** $3,750

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Total Deductibles	$2,000
Co-pays	$20
Co-insurance	$1,580
Limits or exclusions	$150
Total	**$3,750**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $2,600
- **Patient pays:** $2,800

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Total Deductibles	$2,000
Co-pays	$440
Co-insurance	$280
Limits or exclusions	$80
Total	**$2,800**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles, co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.