

# HealthKeepers

## Anthem HealthKeepers 25 POS Open Access / \$10/\$30/\$50 or 20%

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

**Coverage Period:** 01/01/2014 - 12/31/2014

**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](http://www.anthem.com) or by calling 1-855-333-5735.

Important Questions	Answers	Why this Matters:
<b>What is the overall <u>deductible</u>?</b>	<b>\$0</b> single / <b>\$0</b> family for In-Plan Provider <b>\$1000</b> single / <b>\$2000</b> family for Out-of-Plan Provider Does not apply to Prescription Drugs, In-Plan Preventive Care, Copayments, Hospice 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 <b><u>deductible</u></b> amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the <b><u>deductible</u></b> 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 <b><u>deductible</u></b> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
<b>Is there an <u>out-of-pocket limit</u> on my expenses?</b>	Yes; In-Plan Provider Single: <b>\$3500</b> , Family: <b>\$7000</b> Out-of-Plan Provider Single: <b>\$4500</b> , Family: <b>\$9000</b>	The <b><u>out-of-pocket limit</u></b> 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.

**Questions:** Call 1-855-333-5735 or visit us at [www.anthem.com](http://www.anthem.com).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-855-333-5735 to request a copy.

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Important Questions	Answers	Why this Matters:
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Balance-Billed Charges, Pre-Authorization Penalties, Health Care This Plan Doesn't Cover, Premiums, Costs for Prescription Drugs in Tiers 1, 2, and 3, Prescription Drug Copays, Costs Related to Covered Prescription Drugs, Costs Related to Prescription Drugs Covered Under the Prescription Drug Plan, Out-of-Pocket Limit does not include Routine Vision Care.	Even though you pay these expenses, they don't count toward the <b><u>out-of-pocket limit</u></b> .
<b>Is there an overall annual limit on what the insurer pays?</b>	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.
<b>Does this plan use a <u>network of providers</u>?</b>	Yes. See <b>www.anthem.com</b> or call <b>1-855-333-5735</b> 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.
<b>Do I need a referral to see a <u>specialist</u>?</b>	No, you do not need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
<b>Are there services this plan doesn't cover?</b>	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-Plan Provider** 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 <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	\$25 copay	30% coinsurance	—————none—————
	Specialist visit	\$50 copay	30% coinsurance	—————none—————
	Other practitioner office visit	<u>Manipulative Therapy</u> \$25 copay <u>Acupuncturist</u> Not covered	<u>Manipulative Therapy</u> 30% coinsurance <u>Acupuncturist</u> Not covered	<u>Manipulative Therapy</u> Coverage is limited to 30 visits per year per 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)	<u>Lab - Office</u> \$25 copay <u>X-Ray - Office</u> \$25 copay	<u>Lab - Office</u> 30% coinsurance <u>X-Ray - Office</u> 30% coinsurance	<u>Lab - Office</u> 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. <u>X-Ray - Office</u> 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.

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
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
<b>If you need drugs to treat your illness or condition</b>  More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.anthem.com/pharmacyinformation/">www.anthem.com/pharmacyinformation/</a>	Tier 1 – Typically Generic	\$10 copay/ prescription (retail and mail order)	\$10 copay/ prescription (retail and mail order)	Annual Out of Pocket limit \$3500 single/\$12700 family for all covered prescription drug expenses. 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 \$60 copay/prescription (mail order only)	\$30 copay/ prescription (retail only) and \$60 copay/prescription (mail order only)	Annual Out of Pocket limit \$3500 single/\$12700 family for all covered prescription drug expenses. 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 and Specialty Drugs	\$50 or 20% coinsurance, whichever is the greater up to \$200 per script maximum for retail. \$150 or 20% coinsurance, whichever is the greater up to \$400 per script maximum for mail order.	\$50 or 20% coinsurance, whichever is the greater up to \$200 per script maximum for retail. \$150 or 20% coinsurance, whichever is the greater up to \$400 per script maximum for mail order.	Annual Out of Pocket limit \$3500 single/\$12700 family for all covered prescription drug expenses. 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 4 - Not Applicable	Not covered	Not covered	—————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
<b>If you have outpatient Surgery</b>	Facility Fee (e.g., ambulatory surgery center)	\$300 copay	30% coinsurance	—————none—————
	Physician/Surgeon Fees	\$50 copay	30% coinsurance	—————none—————
<b>If you need immediate medical attention</b>	Emergency Room Services	\$250 copay	\$250 copay	No coverage for non emergency use of emergency room. copay waived if admitted
	Emergency Medical Transportation	\$150 copay	\$150 copay	—————none—————
	Urgent Care	\$25 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.
<b>If you have a hospital stay</b>	Facility Fee (e.g., hospital room)	\$350 copay per day up to \$1750 per admission	30% coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced coverage. Copay waived if readmitted for the same condition within less than 72 hours from discharge.
	Physician/surgeon fee	No cost share	30% coinsurance	—————none—————
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	<u>Mental/Behavioral Health Office Visit</u> \$30 copay <u>Mental/Behavioral Health Facility Visit - Facility Charges</u> No cost share	<u>Mental/Behavioral Health Office Visit</u> 30% coinsurance <u>Mental/Behavioral Health Facility Visit - Facility Charges</u> 30% coinsurance	<u>Mental/Behavioral Health Office Visit</u> Medication management, individual therapy up to 30 minutes and group therapy sessions at - \$20 copay.
	Mental/Behavioral health inpatient services	\$350 copay per day up to \$1750 per admission	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
	Substance use disorder outpatient services	<u>Substance Abuse Office Visit</u> \$30 copay <u>Substance Abuse Facility Visit - Facility Charges</u> No cost share	<u>Substance Abuse Office Visit</u> 30% coinsurance <u>Substance Abuse Facility Visit - Facility Charges</u> 30% coinsurance	<u>Substance Abuse Office Visit</u> Medication management, individual therapy up to 30 minutes and group therapy sessions at - \$20 copay.
	Substance use disorder inpatient services	\$350 copay per day up to \$1750 per admission	30% coinsurance	—————none—————
<b>If you are pregnant</b>	Prenatal and postnatal care	\$300 copay	30% coinsurance	Your doctor's charges for delivery are part of prenatal and postnatal care.
	Delivery and all inpatient services	\$350 copay per day up to \$1750 per admission	30% coinsurance	Copay waived if readmitted for the same condition within less than 72 hours from discharge.
<b>If you need help recovering or have other special health needs</b>	Home Health Care	20% coinsurance	30% coinsurance	Coverage is limited to 100 visits per year.
	Rehabilitation Services	\$25 copay	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	\$25 copay	30% coinsurance	Rehabilitation and Habilitation visits count towards your Rehabilitation limit.
	Skilled Nursing Care	20% 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.

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
	Durable medical equipment	20% coinsurance	30% coinsurance	—————none—————
	Hospice service	No cost share	30% coinsurance	—————none—————
<b>If your child needs dental or eye care</b>	Eye exam	\$15 copay	First \$30 is covered in full. After \$30, you pay 100% coinsurance after deductible	Coverage is limited to 1 occurrences per benefit period.
	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 States. See [www.bcbs.com/bluecardworldwide](http://www.bcbs.com/bluecardworldwide).
- Bariatric surgery
- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Infertility treatment
- Long- term care
- Most coverage provided outside the United States.
- 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](http://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

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

(877) 310-6560  
<http://www.scc.virginia.gov/boi>  
[bureauofinsurance@scc.virginia.gov](mailto:bureauofinsurance@scc.virginia.gov)

Or Contact:

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

A consumer assistance program can help you file your appeal. Contact:  
Virginia State Corporation Commission  
Life & Health Division, Bureau of Insurance  
P.O. Box 1157  
Richmond, VA 23218

## 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.

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 adootwoł íínízínigo t'áá diné k'éjígó, t'áá shoodí ba na'ałníhí ya sidáhí bich'í naabídííłkiid. Eí doo biigha daago ni ba'nija'go ho'aalágíí bich'í hodiilní. Hai'daa iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béesh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'í 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: \$6,340
- Patient pays: \$1,200

#### 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
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Total Deductibles	\$0
Co-pays	\$1,010
Co-insurance	\$40
Limits or exclusions	\$150
<b>Total</b>	<b>\$1,200</b>

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

- Amount owed to providers: \$5,400
- Plan pays: \$4,280
- Patient pays: \$1,120

#### 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
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Total Deductibles	\$0
Co-pays	\$790
Co-insurance	\$250
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,120</b>

## 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?

**X 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?

**X 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.

**Questions:** Call 1-855-333-5735 or visit us at [www.anthem.com](http://www.anthem.com).

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