

Your summary of benefits



Anthem. HealthKeepers

HealthKeepers, Inc.

Your Contract Code: 4ACC

Your Plan: Anthem HealthKeepers Platinum OAPOS 10/0%/3500

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	\$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>	\$3,500 person / \$7,000 family	\$8,750 person / \$17,500 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 Office Visit to treat an injury or illness	\$10 copay per visit	30% coinsurance after deductible is met
Enhanced Personal Healthcare Provider Office Visit	\$10 copay per visit	Not Applicable

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Specialist Care Office Visit	\$20 copay per visit	30% coinsurance after deductible is met
Prenatal and Post-natal Care <i>In-Network preventive prenatal services are covered at 100%.</i>	\$200 copay per pregnancy	30% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	\$10 copay per visit	30% coinsurance after deductible is met
Preferred On-line Visit <i>Includes Mental Health and Substance Use Disorder Live Health Online is the preferred telehealth solution. (www.livehealthonline.com).</i>	\$0 copay per visit	30% coinsurance after deductible is met
Other Participating Provider On-line Visit <i>Includes Mental Health and Substance Use Disorder</i>	\$10 copay per visit	30% coinsurance after deductible is met
Chiropractic Services <i>Coverage is limited to 30 visits per benefit period. Coverage for Rehabilitation and Habilitation is limited to 30 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.</i>	\$10 copay per visit	30% coinsurance after deductible is met
Acupuncture	Not covered	Not covered
Other Services in an Office:		
Allergy Testing	\$10 copay per visit	30% coinsurance after deductible is met
Radiation/Chemotherapy/Non Preventive Infusion & Injection	No charge	30% coinsurance after deductible is met
Hemodialysis	No charge	30% coinsurance after deductible is met

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<p>Prescription Drugs <i>For the drugs itself dispensed in the office through infusion/injection.</i></p>	No charge	30% coinsurance after deductible is met
<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>\$200 copay per visit</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>No charge</p> <p>\$200 copay per visit</p> <p>\$200 copay per visit</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</p> <p>Freestanding Radiology Center</p>	<p>\$20 copay per service</p> <p>\$150 copay per service</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>

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Outpatient Hospital	\$150 copay per service	30% coinsurance after deductible is met
Emergency and Urgent Care Urgent Care Center Office Visit	\$20 copay per visit	30% coinsurance after deductible is met
Emergency Room Facility Services <i>Copay waived if admitted.</i>	\$300 copay per visit	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	Covered as In-Network
Emergency Room Mental Health and Substance Use Disorder Doctor Services	\$10 copay per visit	Covered as In-Network
Ambulance Transportation	No charge	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Doctor Office Visit	\$10 copay per visit	30% coinsurance after deductible is met
Facility visit: Facility Fees	\$200 copay per visit	30% coinsurance after deductible is met
Doctor Services	\$10 copay per visit	30% coinsurance after 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>\$200 copay per visit</p> <p>\$200 copay per visit</p> <p>No charge</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>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 100 days combined per admission. 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 \$1,400 per admission</p> <p>No charge</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after 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>Outpatient Hospital <i>Coverage for Physical Therapy and Occupational Therapy is limited to 30 visits combined per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings. Coverage for Speech Therapy is limited to 30 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.</i></p>	\$20 copay per visit	30% coinsurance after deductible is met
<p>Cardiac rehabilitation</p> <p>Office Visit</p> <p>Outpatient Hospital</p>	<p>\$20 copay per visit</p> <p>No charge</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>Physical Medicine, Rehab & Skilled Nursing Facility limited to 100 days combined per admission. Limit is combined In-Network and Non-Network.</i></p>	\$350 copay per day to a maximum of \$1,400 per admission	30% coinsurance after deductible is met
<p>Hospice</p>	No charge	30% coinsurance after deductible is met
<p>Durable Medical Equipment</p>	20% coinsurance	50% coinsurance after deductible is met
<p>Prosthetic Devices <i>Coverage for wigs after cancer treatment is limited to 1 item per benefit period. Limit is combined In-Network and Non-Network.</i></p>	20% coinsurance	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
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>Select 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>	\$10 copay per prescription (retail) and \$25 copay per prescription (home delivery)	30% coinsurance (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>	\$40 copay per prescription (retail) and \$120 copay per prescription (home delivery)	30% coinsurance (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>	25% coinsurance up to \$200 per prescription (retail) and 25% coinsurance up to \$600 per prescription (home delivery)	30% coinsurance (retail) and Not covered (home delivery)
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.</i>	25% coinsurance up to \$400 per prescription (retail and home delivery)	30% coinsurance (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. Benefits include coverage for member's choice of eyeglass lenses or contact lenses, but not both. 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 vision services count towards your out of pocket limit.</i></p>		
<p>Children's Vision Essential Health Benefits (up to age 19)</p>		
<p>Child Vision Deductible</p> <p>Vision exam <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.</i></p>	<p>Not Applicable</p> <p>No charge</p>	<p>Not Applicable</p> <p>\$0 copayment up to plan's Maximum Allowed Amount</p>
<p>Frames <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>\$0 copayment up to plan's Maximum Allowed Amount</p>
<p>Single Vision Lenses <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>\$0 copayment up to plan's Maximum Allowed Amount</p>
<p>Bifocal Vision Lenses <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>\$0 copayment up to plan's Maximum Allowed Amount</p>
<p>Trifocal Vision Lenses <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>\$0 copayment up to plan's Maximum Allowed Amount</p>
<p>Elective contact lenses <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>\$0 copayment up to plan's Maximum Allowed Amount</p>
<p>Non-Elective Contact Lenses <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>\$0 copayment up to plan's Maximum Allowed Amount</p>
<p>Adult Vision (age 19 and older)</p> <p>Adult Vision Deductible</p>	<p>Not Applicable</p>	<p>Not Applicable</p>

Your summary of benefits

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Vision exam <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.</i>	\$20 copay	Reimbursed Up to \$30
Frames	Not covered	Not covered
Single Vision Lenses	Not covered	Not covered
Bifocal Vision Lenses	Not covered	Not covered
Trifocal Vision 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. Only children's dental services count towards your out of pocket limit.</i></p>		
Children's Dental Essential Health Benefits Diagnostic and preventive <i>Coverage for In-Network Providers and Non-Network Providers combined is limited to 2 visits per 12 months.</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Basic services	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Major services	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Medically Necessary Orthodontia services	50% coinsurance after deductible is met	50% coinsurance after deductible is met
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	Not covered	Not covered
Annual maximum	Not covered	Not covered

Your summary of benefits

Your plan also includes the following Healthy Support & Rewards features.

To see your rewards and additional information log into the Anthem website at anthem.com or call the customer service number on your member ID card.

Health Assessment	This tool helps you understand your current health opportunities and identify changes you can make to help improve your health. Subscriber and spouse/domestic partner may be eligible to earn a reward for completing the health assessment each year. In some cases, this activity may require the completion of the Tobacco Certification Program in order to earn the rewards.	Up to \$50 per member per year.
Processed Claim: Adult Wellness Exam	Subscriber and spouse/domestic partner may earn a reward if you complete an annual preventive wellness exam and it is verified by an Anthem claim. This activity requires completion of the Annual Flu Shot in order to earn the rewards.	Up to \$50 per member per year.
Processed Claim: Annual Flu Shot	Subscriber and spouse/domestic partner may earn a reward if you get your annual flu shot and it is verified by an Anthem claim. This activity requires completion of the Adult Wellness Exam in order to earn the rewards.	Up to \$50 per member per year.
Tobacco Certification Program	Subscriber and spouse/domestic partner may earn a reward when you confirm you're tobacco free. It will be only for the current year of your employer's program; you will need to confirm this each year to receive your reward. In some cases, this activity may require the completion of the Health Assessment in order to earn the rewards.	Up to \$50 per member per year.

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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.
- For additional information on this plan, please visit www.sbc.anthem.com to obtain a “Summary of Benefits and Coverage”.
- If readmitted within 72 hours for the same diagnosis of the previous discharge, no additional facility copayment is required.
- If services are rendered by a non-participating provider and your plan includes out of network benefits, you may be responsible for any difference between the covered plan payment and the actual non-participating providers charge. This amount does not apply to the out of network out of pocket limit.
- 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.

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 (855) 330-1214

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 (855) 330-1214.

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՝ (855) 330-1214:

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(855) 330-1214。

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 (855) 330-1214 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 (855) 330-1214.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (855) 330-1214.

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 (855) 330-1214.

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、(855) 330-1214 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(855) 330-1214로 문의하십시오.

Language Access Services:

Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'idiikidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehj̄ bee nił hodoonih t'áadoo bą́ąh ilínígóó. Ata' halne'ígíí la' bich'į' hadeesdzih ninizingo kojį' hodíilnih (855) 330-1214.

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: (855) 330-1214.

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, (855) 330-1214 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. (855) 330-1214.

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 (855) 330-1214.

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 (855) 330-1214.

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 (855) 330-1214.

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>.