Your summary of benefits

Anthem. HealthKeepers

Anthem® HealthKeepers Inc.

Your 2022 Contract Code: 66MC

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 *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$0 person / $0 family	$2,000 person / $4,000 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.*	$3,500 person / $7,000 family	$8,750 person / $17,500 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
<u>Virtual Care (Telemedicine / Telehealth Visits)</u> **Virtual Visits with Doctors who also provide services in person** Primary Care (PCP)	**<u>Preferred PCP</u>** $10 copay per visit **<u>PCP</u>** $10 copay per visit	30% coinsurance after deductible is met

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Mental Health and Substance Abuse care	$10 copay per visit	30% coinsurance after deductible is met
Specialist	$30 copay per visit	30% coinsurance after deductible is met
Medical Chats and Virtual (Video) Visits for Primary Care *from our Online Provider K Health, through its affiliated Provider groups*	No charge	
Virtual Visits from Online Provider LiveHealth Online - *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*		
Primary Care (PCP) and Mental Health and Substance Abuse	$5 copay per visit	
Specialist Care	$30 copay per visit	
Visits in an Office		
Primary Care (PCP)	**Preferred PCP** $10 copay per visit **PCP** $10 copay per visit	30% coinsurance after deductible is met
Specialist Care	$30 copay per visit	30% coinsurance after deductible is met

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal) *In-Network preventive prenatal services are covered at 100%.*	$300 copay per pregnancy	30% coinsurance after deductible is met
Retail Health Clinic	$10 copay per visit	30% coinsurance after deductible is met
Chiropractic Services *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.*	$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
Dialysis/Hemodialysis	No charge	30% coinsurance after deductible is met
Prescription Drugs - Dispensed in the office *For the drugs itself dispensed in the office through infusion/injection.*	20% coinsurance	30% coinsurance after deductible is met
Surgery	$30 copay per surgery	30% coinsurance after deductible is met

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<u>Diagnostic Services</u>		
Lab		
Office	No charge	30% coinsurance after deductible is met
Preferred Reference Lab	No charge	30% coinsurance after deductible is met
Outpatient Hospital	$30 copay per visit	30% coinsurance after deductible is met
X-Ray		
Office	No charge	30% coinsurance after deductible is met
Freestanding Radiology Center	$10 copay per visit	30% coinsurance after deductible is met
Outpatient Hospital	$30 copay per visit	30% coinsurance after deductible is met
Advanced Diagnostic Imaging - for example: MRI, PET and CAT scans		
Office	$30 copay per service	30% coinsurance after deductible is met
Freestanding Radiology Center	$100 copay per service	30% coinsurance after deductible is met
Outpatient Hospital	$200 copay per service	30% coinsurance after deductible is met

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<u>**Emergency and Urgent Care**</u>		
Urgent Care Center Office Visit	$30 copay per visit	30% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$350 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 Abuse Doctor Services	$10 copay per visit	Covered as In-Network
Ambulance Transportation	No charge	Covered as In-Network
<u>**Outpatient Mental Health and Substance Abuse**</u>		
Doctor Office Visit	$10 copay per visit	30% coinsurance after deductible is met
Facility visit		
Facility Fees	$300 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
<u>Outpatient Surgery</u>		
Facility Fees		
Hospital	$300 copay per visit	30% coinsurance after deductible is met
Freestanding Surgical Center	$200 copay per visit	30% coinsurance after deductible is met
Doctor and Other Services		
Hospital	No charge	30% coinsurance after deductible is met
Freestanding Surgical Center	$30 copay per visit	30% coinsurance after deductible is met
<u>Hospital Stay (all Inpatient stays including Maternity, Mental Health and Substance Abuse)</u> *If readmitted within 72 hours for the same diagnosis of the previous discharge, no additional facility copayment is required. If transferred between facilities, only one copayment will apply.*		
Facility fees (for example, room & board) *Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 100 days combined per admission. Limit is combined In-Network and Non-Network.*	$400 copay per day to a maximum of $1,600 per admission	30% coinsurance after deductible is met
Doctor and other services	No charge	30% coinsurance after deductible is met

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<u>Recovery & Rehabilitation</u>		
Home Health Care *Coverage is limited to 100 visits per benefit period. Private Duty Nursing included with Home Health Care is limited to 16 hours per benefit period. Limit is combined In-Network and Non-Network. Visit limit does not apply to Home Infusion Therapy or Home Dialysis.*	20% coinsurance	30% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy) *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. Benefit limit does not apply to Applied Behavioral Analysis. Visit limit does not apply when performed as part of Early Intervention or Hospice. When rendered in the home, the Home Care visit limit applies instead of the Therapy Services limits.*		
Office	$10 copay per visit	30% coinsurance after deductible is met
Outpatient Hospital	$30 copay per visit	30% coinsurance after deductible is met
Habilitation services (for example, physical/speech/occupational therapy) *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. Benefit limit does not apply to Applied Behavioral Analysis.*		
Office	$10 copay per visit	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	$30 copay per visit	30% coinsurance after deductible is met
Cardiac rehabilitation		
Office Visit	$30 copay per visit	30% coinsurance after deductible is met
Outpatient Hospital	No charge	30% coinsurance after deductible is met
Pulmonary rehabilitation		
Office	$30 copay per visit	30% coinsurance after deductible is met
Outpatient Hospital	No charge	30% coinsurance after deductible is met
Skilled Nursing Care (in a facility) *Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 100 days combined per admission. Limit is combined In-Network and Non-Network.*	$400 copay per day to a maximum of $1,600 per admission	30% coinsurance after deductible is met
Inpatient Hospice	No charge	30% coinsurance after deductible is met
Durable Medical Equipment	20% coinsurance	50% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period. Limit is combined In-Network and Non-Network.*	20% coinsurance	30% coinsurance after deductible is met

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Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out of Pocket	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Prescription Drug Coverage *Cost shares for drugs included on the Select drug list appear below. Drugs not included on the Select drug list will not be covered. Your plan uses the Advantage Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies.*		
Home Delivery Pharmacy *Maintenance medications are available through IngenioRx Home Delivery Pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.*		
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery). 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.*	$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 *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery). 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.*	$45 copay per prescription, deductible does not apply (retail) and $135 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 *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery). Coverage is also provided for up to a 12-month supply*	25% coinsurance up to $200 per prescription,	30% coinsurance, deductible does not apply (retail) and

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time.	deductible does not apply (retail) and 25% coinsurance up to $600 per prescription, deductible does not apply (home delivery)	Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) *Per 30 day supply (specialty pharmacy). 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.*	25% coinsurance up to $400 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
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. *Only children's vision services count towards your out of pocket limit.*		
Children's Vision Essential Health Benefits (up to age 19)		
Child Vision Deductible	Not Applicable	Not Applicable
Vision exam *Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Frames *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Single Vision Lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Bifocal Vision Lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Trifocal Vision Lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Elective contact lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Non-Elective Contact Lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Adult Vision (age 19 and older)		
Adult Vision Deductible	Not Applicable	Not Applicable
Vision exam	$20 copay	Reimbursed Up to $30

Your summary of benefits

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.		
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
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 Providers and Non-Network Providers combined is limited to 2 visits per 12 months.*	0% coinsurance	30% coinsurance after deductible is met
Basic services	40% coinsurance	50% coinsurance after deductible is met
Major services	50% coinsurance	50% coinsurance after deductible is met
Medically Necessary Orthodontia services	50% coinsurance	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		
Annual maximum	Not covered	Not covered

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.*		
Smart Rewards	Subscriber and spouse/domestic partner may earn rewards when eligible activities are completed and, in some instances, are verified by an Anthem claim.	Up to $200 per member per year

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.
- You are encouraged to select a Primary Care Physician (PCP). Choosing a PCP is an important decision. Call us at the number on your ID card and we'll help you pick a doctor.
- Preferred PCP refers to primary care providers that participate in our EPHC (Enhanced Personal Health Care) program.
- For additional information on this plan, please visit www.sbc.anthem.com to obtain a "Summary of Benefits and Coverage".
- 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.

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Language Access Services:

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 1214-330 (855) .

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 شفاهی، با شماره 1214-330 (855) 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.

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Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bína'ídíłkidgo ná bohónéedzą́ dóó bee ahóót'i' t'áá ni nizaad k'ehjį bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínízingo kojį' hodíílnih (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 ਮੁਫ਼ਤ 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.

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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.