Anthem® HealthKeepers Inc.

Your Contract Code: 6F25

Your Plan: Anthem HealthKeepers POS OA 30 1000/20%/4500 Rx $15/$50/$85/20%, Rx Choice Tiered

Your Network: HealthKeepers

| **Covered Medical Benefits** | **Cost if you use an In-Network Provider** | **Cost if you use a Non-Network Provider** |
| --- | --- | --- |
| **Overall Deductible** | $1,000 person / $2,000 family | $2,000 person / $4,000 family |
| **Out-of-Pocket Limit** | $4,500 person / $9,000 family | $11,250 person / $22,500 family |
| The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per person 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 per person deductible or per person out-of-pocket maximum.  Your copays, coinsurance and deductible count toward your out of pocket amount(s).  In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other. | | |
| **Preventive Care / Screening / Immunization** | No charge | 30% coinsurance after medical deductible is met |
| **Preventive Care for Chronic Conditions** *per IRS guidelines* | No charge | 30% coinsurance after medical deductible is met |
| **Virtual Care (Telemedicine / Telehealth Visits)** |  |  |
| **Virtual Visits - Online visits with Doctors who also provide services in person** |  |  |
| Primary Care (PCP) | **Preferred PCP**  $20 copay per visit medical deductible does not apply  **PCP**  $30 copay per visit medical deductible does not apply | 30% coinsurance after medical deductible is met |
| Mental Health and Substance Abuse care | $30 copay per visit medical deductible does not apply | 30% coinsurance after medical deductible is met |
| Specialist | $50 copay per visit medical deductible does not apply | 30% coinsurance after medical 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*](http://www.livehealthonline.com)*; our mobile app, website or Anthem-enabled device* |  | |
| Primary Care (PCP) and Mental Health and Substance Abuse | $5 copay per visit medical deductible does not apply | |
| Specialist Care | $50 copay per visit medical deductible does not apply | |
| **Visits in an Office** |  |  |
| **Primary Care (PCP)** | **Preferred PCP**  $20 copay per visit medical deductible does not apply  **PCP**  $30 copay per visit medical deductible does not apply | 30% coinsurance after medical deductible is met |
| **Specialist Care** | $50 copay per visit medical deductible does not apply | 30% coinsurance after medical deductible is met |
| **Other Practitioner Visits** |  |  |
| **Routine Maternity Care** (Prenatal and Postnatal) | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Retail Health Clinic** | $30 copay per visit medical deductible does not apply | 30% coinsurance after medical deductible is met |
| **Manipulation Therapy**  *Coverage is limited to 30 visits per benefit period.* | $30 copay per visit medical deductible does not apply | 30% coinsurance after medical deductible is met |
| **Other Services in an Office** |  |  |
| **Allergy Testing** | $20 copay per visit medical deductible does not apply | 30% coinsurance after medical deductible is met |
| **Chemo/Radiation Therapy** | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Dialysis/Hemodialysis** | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Prescription Drugs** *Dispensed in the office* | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Surgery** | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Diagnostic Services**  **Lab** |  |  |
| Office | No charge | 30% coinsurance after medical deductible is met |
| Preferred Reference Lab | No charge | 30% coinsurance after medical deductible is met |
| Outpatient Hospital | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **X-Ray** |  |  |
| Office | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| Outpatient Hospital | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Advanced Diagnostic Imaging** *for example: MRI, PET and CAT scans* |  |  |
| Office | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| Outpatient Hospital | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Emergency and Urgent Care** |  |  |
| **Urgent Care** | $50 copay per visit medical deductible does not apply | 30% coinsurance after medical deductible is met |
| **Emergency Room Facility Services** | 20% coinsurance after medical deductible is met | Covered as In-Network |
| **Emergency Room Doctor and Other Services** | 20% coinsurance after medical deductible is met | Covered as In-Network |
| **Ambulance** | 20% coinsurance after medical deductible is met | Covered as In-Network |
| **Outpatient Mental Health and Substance Abuse** |  |  |
| **Doctor Office Visit** | $30 copay per visit medical deductible does not apply | 30% coinsurance after medical deductible is met |
| **Facility Visit** |  |  |
| Facility Fees | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| Doctor Services | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Outpatient Surgery** |  |  |
| **Facility Fees** |  |  |
| Hospital | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| Freestanding Surgical Center | $300 copay per visit medical deductible does not apply | 30% coinsurance after medical deductible is met |
| **Doctor and Other Services** |  |  |
| Hospital | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Hospital (Including Maternity, Mental Health and Substance Abuse)** |  |  |
| **Facility Fees** | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Doctor and other services** | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Recovery & Rehabilitation** |  |  |
| **Home Health Care**  *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.* | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Rehabilitation services**  *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period.* |  |  |
| Office | $30 copay per visit medical deductible does not apply | 30% coinsurance after medical deductible is met |
| Outpatient Hospital | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Cardiac rehabilitation**  *Coverage is limited to 36 visits per benefit period.* |  |  |
| Office | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| Outpatient Hospital | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Skilled Nursing Care (facility)**  *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.* | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Inpatient Hospice** | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Durable Medical Equipment** | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Prosthetic Devices**  *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.* | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |

| **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 Limit** | 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 Essential drug list appear below. Drugs not included on the Essential drug list will not be covered. Your plan uses the Rx Choice Tiered Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies.* | | |
| **Home Delivery Pharmacy** *Maintenance medication 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).* | $15 copay per prescription at Level 1 pharmacy (retail only). $25 copay per prescription at Level 2 pharmacy (retail only). $15 copay per  prescription (home  delivery only) | 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).* | $50 copay per prescription at Level 1 pharmacy (retail only). $60 copay per  prescription at Level 2 pharmacy (retail only). $100 copay per  prescription (home delivery only)) | 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).* | $85 copay per prescription at Level 1 pharmacy (retail only). $95 copay per prescription at Level 2 pharmacy (retail only). $255 copay per prescription  (home delivery only) | 30% coinsurance, deductible does not apply (retail) and Not covered (home delivery) |
| **Tier 4 - Typically Specialty (brand and generic)**  *Per 30 day supply (specialty pharmacy).* | 20% coinsurance up to $300 per prescription at Level 1 pharmacy and up to $350 per prescription at Level 2 pharmacy. Retail and Home Delivery) | 30% coinsurance, deductible does not apply (retail) and Not covered (home delivery) |

| **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. Only children's vision services count towards your out of pocket limit.* | | |
| **Children's Vision (up to age 19)** |  |  |
| **Child Vision Deductible** | $0 person | $0 person |
| **Vision exam**  *Limited to 1 exam per benefit period.* | No charge | Reimbursed Up to $30 |
| **Adult Vision (age 19 and older)** |  |  |
| **Adult Vision Deductible** | $0 person | $0 person |
| **Vision exam**  *Limited to 1 exam per benefit period.* | $15 copay | Reimbursed Up to $30 |

**Notes:**

* The representations of benefits in this document are subject to Division of Insurance approval and are subject to change.
* If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under “Outpatient Facility Services”.
* Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.

*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 on limitations and exclusions that apply to our medical plans. Visit* [*https://www.anthemplancomparison.com/va*](https://www.anthemplancomparison.com/va) *to access this information.*

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# 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)**

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| . (833) 592-9956 | image13 |

**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。

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**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 nenpòt 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.

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**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.

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| image21 | image22 | (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.

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**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>](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf). Complaint forms are available at [<http://www.hhs.gov/ocr/office/file/index.html>](http://www.hhs.gov/ocr/office/file/index.html).