Your summary of benefits

Anthem® HealthKeepers Inc.

Your Plan: Henrico County General Government and Public Schools : Premier POS

Your Network: HealthKeepers

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *Your plan applies a separate Pharmacy Deductible to prescription drugs obtained at a pharmacy. See the Covered Prescription Drug Benefits section.*	$300 person / $300 family	$400 person / $800 family
Overall Out-of-Pocket Limit	$2,500 person / $5,000 family	$2,500 person / $5,000 family
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit. Your copays, coinsurance and deductible count toward your out of pocket limit(s). In-Network and Non-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Medical Chats and Virtual Visits for Primary Care *from our Online Provider K Health, through its affiliated Provider groups are covered at No charge deductible does not apply.*		
Virtual Visits from online provider LiveHealth Online *for urgent/acute medical and mental health and substance abuse care via www.livehealthonline.com are covered at $0 copay per visit medical deductible does not apply.*		
Primary Care (PCP) *virtual and office*	$20 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Mental Health and Substance Abuse Care *virtual and office*	$20 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Specialist Care *virtual and office*	$40 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	$50 copay per pregnancy medical deductible does not apply	30% coinsurance after medical deductible is met
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$20 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.*	$20 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Other Services in an Office		
Allergy Testing	$20 PCP/$40 SPC copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Prescription Drugs *Dispensed in the office*	$20 PCP/$40 SPC copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Surgery	$20 PCP/$40 SPC copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Preventive care / screenings / immunizations	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
Diagnostic Services **Lab**		
Office	No charge	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Preferred Reference Lab	No charge	30% coinsurance after medical deductible is met
Outpatient Hospital	No charge	30% coinsurance after medical deductible is met
X-Ray		
Office	No charge	30% coinsurance after medical deductible is met
Outpatient Hospital	No charge	30% coinsurance after medical deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	5% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Outpatient Hospital	5% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	$20 PCP/$40 SPC copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$150 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Emergency Room Doctor and Other Services	No charge	Covered as In-Network
Ambulance	No charge	30% coinsurance after medical deductible is met
Outpatient Mental Health and Substance Abuse Care at a Facility		
Facility Fees	0% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Doctor Services	$20 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Outpatient Surgery **Facility Fees**		
Hospital	5% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Ambulatory Surgical Center	5% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Doctor and Other Services		
Hospital	5% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	5% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Physician and other services *including surgeon fees*	5% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Home Health Care *Coverage is limited to 90 visits per benefit period.*	$40 copay per visit after medical deductible is met	30% coinsurance after medical deductible is met
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for physical and occupational therapies is limited to 30 visits combined per benefit period. Coverage for speech therapy is limited to 30 visits per benefit period.*		
Office and Outpatient Hospital	$25 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Pulmonary rehabilitation *office and outpatient hospital*	5% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Cardiac rehabilitation *office and outpatient hospital*	5% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	No charge	30% coinsurance after medical deductible is met
Chemo/Radiation Therapy *office and outpatient hospital*	No charge	30% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Coverage is limited to 100 days per admission.*	5% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Inpatient Hospice	5% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Durable Medical Equipment	No charge	30% coinsurance after medical deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	5% 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	$150 person / $150 family	$150 person / $150 family
Prescription Drug Coverage **Network:** ***Base Network*** **Drug List:** ***National Direct -*** *Drugs not included on the drug list will not be covered. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.*		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail. You will need to call us on the number on your ID card to sign up when you first use the service.* **Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.*		

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Tier 1 - Typically Generic	$10 copay per prescription after Pharmacy deductible is met (retail and home delivery)	$10 copay per prescription after Pharmacy deductible is met (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand	$30 copay per prescription, after Pharmacy deductible is met (retail) and $60 copay per prescription after Pharmacy deductible is met (home delivery)	$30 copay per prescription after Pharmacy deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand/Specialty Drugs	$55 copay per prescription, after Pharmacy deductible is met (retail) and $165 copay per prescription after Pharmacy deductible is met (home delivery)	$55 copay per prescription after Pharmacy deductible is met (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. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out of pocket limit.		
Children's Vision exam (up to age 19) *Limited to 1 exam per benefit period.*	$15 copay	Reimbursed Up to $30
Adult Vision exam (age 19 and older) *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 to access this information.

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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 (833) 630-6742

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 (833) 630-6742 .

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) 630-6742:

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Farsi (فارسي): 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 (833) 630-6742 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 (833) 630-6742.

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Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'idiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí łą' bich'į' hadeesdzih ninízingo kojį' hodíilnih (833) 630-6742.

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