Your benefits

Anthem HealthKeepers/Standard POS Plan/Open Access

Anthem HealthKeepers
Offered by HealthKeepers, Inc.

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 $0 copay per visit medical 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 $5 copay per visit medical deductible does not apply.		
Primary care (PCP) Virtual and office	**$25 copay** per visit medical deductible does not apply	**30%** coinsurance after medical deductible is met
Mental health and substance abuse care Virtual and office	**$25 copay** per visit medical deductible does not apply	**30%** coinsurance after medical deductible is met
Specialist care Virtual and office	**$45 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.	**$25 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.	**$45 copay** per visit medical deductible does not apply	**30%** coinsurance after medical deductible is met
Other services in an office		
Allergy testing	**$25 PCP/$45 SPC copay** per visit medical deductible does not apply	**30%** coinsurance after medical deductible is met
Prescription drugs Dispensed in the office	**$25 PCP/$45 SPC copay** per visit medical deductible does not apply	**30%** coinsurance after medical deductible is met
Surgery	**$25 PCP/$45 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
Preferred reference lab	**No charge**	**30%** coinsurance after medical deductible is met
Outpatient hospital	**No charge**	**30%** coinsurance after medical deductible is met

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Diagnostic services *(continued)*		
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	**10%** coinsurance after medical deductible is met	**30%** coinsurance after medical deductible is met
Outpatient hospital	**30%** 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.	**$25 PCP/$45 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	Covered as in-network
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
Doctor services	**0%** coinsurance after medical deductible is met	**30%** coinsurance after deductible is met
Outpatient surgery		
Facility fees		
Hospital	**30%** coinsurance after medical deductible is met	**30%** coinsurance after medical deductible is met
Ambulatory surgical center	**30%** coinsurance after medical deductible is met	**30%** coinsurance after medical deductible is met
Doctor and other services		
Hospital	**30%** coinsurance after medical deductible is met	**30%** coinsurance after medical deductible is met
Hospital (including maternity, mental health and substance abuse)		
Facility fees	**30%** coinsurance after medical deductible is met	**30%** coinsurance after medical deductible is met
Physician and other services including surgeon fees	**30%** 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.	**$45 copay** per visit after medical deductible is met	**30%** coinsurance after 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.		
Rehabilitation and habilitation services Office and outpatient hospital	**$45 copay** per visit medical deductible does not apply	**30%** coinsurance after deductible is met
Pulmonary rehabilitation Office and outpatient hospital	**30%** coinsurance after medical deductible is met	**30%** coinsurance after medical deductible is met
Cardiac rehabilitation Office and outpatient hospital	**30%** 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

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Covered medical benefits	Cost if you use an in-network provider	Cost if you use a non-network provider
Chemo/Radiation therapy Office and outpatient hospital	**No charge**	**30%** coinsurance after medical deductible is met
Skilled nursing care (facility) Coverage for Inpatient rehabilitation and skilled nursing services is limited to 100 days combined per admission.	**30%** coinsurance after medical deductible is met	**30%** coinsurance after medical deductible is met
Inpatient hospice	**30%** coinsurance after medical deductible is met	**30%** coinsurance after medical deductible is met
Durable medical equipment	**0%** 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.	**30%** 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.		
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** per visit deductible does not apply	Reimbursed up to **$30**
Adult vision exam (age 19 and older) Limited to 1 exam per benefit period.	**$15 copay** per visit deductible does not apply	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 **www.anthemplancomparison.com/va** to access this information.