Your summary of benefits

Anthem® HealthKeepers Inc.

Your Contract Code: 5VJF

Your Plan: Anthem HealthKeepers POS OA 15/20%/4000 Rx $10/$30/$45/20%

Your Network: HealthKeepers

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$0 person / $0 family	$400 person / $800 family
Out-of-Pocket Limit	$4,000 person / $8,000 family	$6,000person / $12,000 family
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.		
Preventive Care / Screening / Immunization	No charge	30% coinsurance after medical deductible is met
Doctor Home and Office Services		
Primary Care Visit	$15 copay per visit	30% coinsurance after medical deductible is met
Enhanced Personal Healthcare Provider Office Visit	$10 copay per visit	Not Applicable
Specialist Care Visit	$35 copay per visit	30% coinsurance after medical deductible is met
Prenatal and Post-natal Care	$300 copay per pregnancy	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
Other Practitioner Visits:		
Retail Health Clinic	$15 copay per visit	30% coinsurance after medical deductible is met
Preferred On-line Visit *Includes Mental Health and Substance Abuse* *Live Health Online is the preferred telehealth solution.* *(www.livehealthonline.com).*	$10 copay per visit	30% coinsurance after medical deductible is met
Other Participating Provider On-line Visit *Includes Mental Health and Substance Abuse*	$15 copay per visit	30% coinsurance after medical deductible is met
Manipulation Therapy *Coverage is limited to 30 visits per benefit period.*	$25 copay per visit	30% coinsurance after medical deductible is met
Other Services in an Office:		
Allergy Testing	$10 copay per visit	30% coinsurance after medical deductible is met
Chemo/Radiation Therapy	$35 copay per visit	30% coinsurance after medical deductible is met
Dialysis/Hemodialysis	20% coinsurance	30% coinsurance after medical deductible is met
Prescription Drugs - *Dispensed in the office*	20% coinsurance	30% coinsurance after medical deductible is met
Diagnostic Services **Lab:**		
Office	$15 PCP / $35 Specialist per visit	30% coinsurance after medical deductible is met
Preferred Reference Lab	No charge	30% coinsurance after medical deductible is met
Outpatient Hospital	$35 copay per visit	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
X-Ray:		
Office	$15 PCP / $35 Specialist per visit	30% coinsurance after medical deductible is met
Outpatient Hospital	$35 copay per visit	30% coinsurance after medical deductible is met
Advanced Diagnostic Imaging:		
Office	20% coinsurance	30% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance	30% coinsurance after medical deductible is met
Emergency and Urgent Care		
Urgent Care	$35 copay per visit	30% coinsurance after medical deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$250 copay per visit	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	Covered as In-Network
Ambulance	$150 copay per transport	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	$15 copay per visit	30% coinsurance after medical deductible is met
Facility Visit:		
Facility Fees	No charge	30% coinsurance after medical deductible is met
Doctor Services	$30 copay per visit	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
Outpatient Surgery		
Facility Fees:		
Hospital	$300 copay per visit	30% coinsurance after medical deductible is met
Freestanding Surgical Center	$150 copay per visit	30% coinsurance after medical deductible is met
Doctor and Other Services:		
Hospital	No charge	30% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):		
Facility Fees	$250 copay per day to a maximum of $1,250 per admission	30% coinsurance after medical deductible is met
Doctor and other services	No charge	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	30% coinsurance after medical deductible is met
Rehabilitation services:		
Office *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.*	$25 copay per visit	30% coinsurance after medical deductible is met
Outpatient Hospital *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.*	20% coinsurance	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 *Coverage is limited to 36 visits per benefit period.* Outpatient Hospital *Coverage is limited to 36 visits per benefit period.*	 $35 copay per visit $35 copay per visit	 30% 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	30% coinsurance after medical deductible is met
Hospice	No charge	30% coinsurance after medical deductible is met
Durable Medical Equipment	20% coinsurance	30% coinsurance after medical deductible is met
Prosthetic Devices	20% coinsurance	30% coinsurance after medical deductible is met

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	Combined with medical
Prescription Drug Coverage *National with R90 and Optional Home Delivery* *Essential Drug List* *This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs.*		
Tier 1 - Typically Generic *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$10 copay per prescription, deductible does not apply (retail) and $25 copay per prescription, deductible	$10 copay per prescription, deductible does not apply (retail) and Not covered (home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
	does not apply (home delivery)	
Tier 2 – Typically Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$30 copay per prescription, deductible does not apply (retail) and $75 copay per prescription, deductible does not apply (home delivery)	$30 copay per prescription, deductible does not apply(retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$45 copay per prescription, deductible does not apply (retail) and $113 copay per prescription, deductible does not apply (home delivery)	$45 copay per prescription, deductible does not apply (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) *30 day supply (retail pharmacy). 30 day supply (home delivery).*	20% coinsurance up to $250 per prescription, deductible does not apply (retail and home delivery)	20% coinsurance up to $250 per prescription, 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.		
Child Vision exam *Limited to 1 exam per benefit period.*	No charge	Reimbursed Up to $30
Adult Vision exam *Limited to 1 exam per benefit period.*	$15 copay	Reimbursed Up to $30

Notes:

- Your copays, coinsurance and deductible count toward your out of pocket amount.
- The representations of benefits in this document are subject to Division of Insurance approval and are subject to change.

- If you have a visit with your Primary Care Physician, Specialist or Urgent Care at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services" which is generally coinsurance or coinsurance after your deductible is met.
  Costs may also 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 to the applicable Anthem HealthKeepers Inc. enrollment brochure.

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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) 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)

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) 592-9956 .

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。

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) 592-9956 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) 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.

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、(833) 592-9956 にお電話ください。

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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) 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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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. (833) 592-9956.

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