

Your summary of benefits



Anthem. HealthKeepers

Anthem® HealthKeepers Inc.

Your Plan: HSA 1500 NonEmbedded

Your Network: HealthKeepers

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$1,500 person / \$3,000 family	\$3,000 person / \$6,000 family
Out-of-Pocket Limit	\$5,500 person / \$11,000 family	\$7,000 person / \$14,000 family
<p>The family deductible is non-embedded meaning the cost shares of all family members apply to one shared family deductible. The individual deductible only applies to individuals enrolled under single coverage.</p> <p>The family out-of-pocket maximum is embedded meaning the cost shares of one family member will be applied to the individual out-of-pocket maximum; in addition, amounts for all covered family members will apply to the family out-of-pocket maximum. No one member will pay more than the individual out-of-pocket maximum.</p> <p>Your copays, coinsurance, and deductible count toward your out-of-pocket amount(s).</p> <p>In-network and out-of-network deductible and out-of-pocket maximum amounts are separate and do not accumulate toward each other.</p>		
Preventive Care / Screening / Immunization	No charge	50% coinsurance after deductible is met
<u>Doctor Home and Office Services</u>		
Primary Care Visit	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Specialist Care Visit	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Prenatal and Post-natal Care	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<u>Other Practitioner Visits:</u>		
Medical Chats	0% coinsurance after deductible is met	Not Applicable
Retail Health Clinic	20% coinsurance after deductible is met	50% coinsurance after deductible is met
On-line Visit <i>Includes Mental Health and Substance Abuse</i> <i>Live Health Online is the preferred telehealth solution.</i> www.livehealthonline.com	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Questions: (833) 988-2030 or visit us at www.anthem.com

VA/LG/Anthem HealthKeepers HSA 1500NE 01-01-2023

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Manipulation Therapy <i>Coverage is limited to 30 visits per benefit period.</i>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<u>Other Services in an Office:</u> Allergy Testing Chemo/Radiation Therapy Dialysis/Hemodialysis Prescription Drugs - <i>injected / infused in the office</i>	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met
<u>Diagnostic Services</u> Lab: Office Preferred Reference Lab Outpatient Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met
X-Ray: Office Outpatient Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met
Advanced Diagnostic Imaging: Office Outpatient Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<u>Emergency and Urgent Care</u> Urgent Care	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency Room Facility Services Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	Covered as In-Network
<u>Ambulance</u>	20% coinsurance after deductible is met	Covered as In-Network
<u>Outpatient Mental/Behavioral Health and Substance Abuse</u> Doctor Office Visit Facility Visit: Facility Fees Doctor Services	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<u>Outpatient Surgery</u> Facility Fees: Hospital Freestanding Surgical Center Doctor and Other Services: Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><u>Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):</u></p> <p>Facility Fees</p> <p>Doctor and other services</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><u>Recovery & Rehabilitation</u></p> <p>Home Health Care <i>Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.</i></p>	<p>0% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p>
<p>Rehabilitation services:</p> <p>Office <i>Coverage for rehabilitative and habilitative physical therapy, occupational therapy and speech therapy is limited to 30 visits each per benefit period in network & out of network combined and office & outpatient combined.</i></p> <p>Outpatient Hospital <i>Coverage for rehabilitative and habilitative physical therapy, occupational therapy and speech therapy is limited to 30 visits each per benefit period in network & out of network combined and office & outpatient combined.</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p>Cardiac & Pulmonary Rehabilitation</p> <p>Office <i>Coverage is limited to 30 visits each per benefit period for cardiac and pulmonary rehabilitation in network & out of network combined and office & outpatient combined.</i></p> <p>Outpatient Hospital <i>Coverage is limited to 30 visits each per benefit period for cardiac and pulmonary rehabilitation in network & out of network combined and office & outpatient combined.</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p>Skilled Nursing Care (facility) <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 100 days each per benefit period. Limit is combined for in network and out of network</i></p>	<p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p>
<p>Hospice</p>	<p>0% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p>
<p>Durable Medical Equipment <i>Wigs needed due to cancer are limited to one per year</i></p>	<p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prosthetic Devices	20% coinsurance after deductible is met	50% coinsurance after 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	Combined with medical deductible	Combined with medical deductible
Pharmacy Out of Pocket	Combined with medical	Combined with medical
<p>Prescription Drug Coverage <i>National Network</i> <i>National Direct Drug List</i> <i>No coverage for non-formulary drugs.</i> <i>R90 – 90 day retail</i></p> <p><i>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 this service.</i></p>		
<p>Tier 1 - Typically Generic <i>30 day supply (retail pharmacy). 90 day supply (retail and home delivery).</i></p>	<p>\$10 copay per prescription, after deductible is met (retail) and \$20 copay per prescription, after deductible is met (retail and home delivery)</p>	<p>\$10 copay per prescription, after deductible is met (retail) and \$20 copay per prescription, after deductible is met (90 day retail) Not covered (home delivery)</p>
<p>Tier 2 – Typically Preferred Brand <i>30 day supply (retail pharmacy). 90 day supply (retail and home delivery).</i></p>	<p>\$30 copay per prescription, after deductible is met (retail) and \$60 copay per prescription, after deductible is met (90 day retail and home delivery)</p>	<p>\$30 copay per prescription, after deductible is met (retail) and \$60 copay per prescription, after deductible is met (90 day retail) Not covered (home delivery)</p>
<p>Tier 3 - Typically Non-Preferred Brand <i>30 day supply (retail pharmacy). 90 day supply (retail and home delivery).</i></p>	<p>\$60 copay per prescription, after deductible is met (retail) and \$120 copay per prescription, after deductible is met (90 day retail and home delivery)</p>	<p>\$60 copay per prescription, after deductible is met (retail) and \$120 copay per prescription, after deductible is met (90 day retail) Not covered (home delivery)</p>

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<i>This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.</i>		
Child Vision exam <i>Limited to 1 exam per benefit period.</i>	No charge	Reimbursed Up to \$30
Adult Vision exam <i>Limited to 1 exam per benefit period.</i>	\$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 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” which is generally coinsurance or coinsurance after your deductible is met.
- 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 to the applicable Anthem HealthKeepers Inc. enrollment brochure.

Intentionally Left Blank

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) 988-2030

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) 988-2030.

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) 988-2030:

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) 988-2030。

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 (833) 988-2030 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) 988-2030.

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) 988-2030.

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) 988-2030.

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) 988-2030 にお電話ください。

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(833) 988-2030로 문의하십시오.

Language Access Services:

Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'idílkidgo ná bohónéedzą dóó bee ahóót'i' t'áa ni nizaad k'ehjí bee nił hodoonih t'áadoo bąąh ilinígóó. Ata' halne'ígíí la' bich'i' hadeesdzih nínizingo kojí' hodiłnih (833) 988-2030.

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) 988-2030.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (833) 988-2030 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. (833) 988-2030.

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) 988-2030.

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) 988-2030.

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) 988-2030.

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>.