

Your summary of benefits



And Its Affiliate HealthKeepers, Inc.

Anthem® Blue Cross and Blue Shield and Its Affiliate HealthKeepers, Inc.

Prince George County - Wellness Plan

Your Contract Code: Custom

07/01/2022 - 06/30/2023

Your Plan: Anthem POS AdvantageOne HSA 3000/0%/4000 Rx \$10/\$40/\$60/20% w/ Preventive Rx Enhanced

Your Network: HealthKeepers

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$3,000 person / \$6,000 family	\$6,000 person / \$12,000 family
Out-of-Pocket Limit	\$4,000 person / \$8,000 family	\$10,000 person / \$20,000 family
<p>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.</p> <p>Your copays, coinsurance and deductible count toward your out of pocket amount(s).</p> <p>In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other.</p>		
Preventive Care / Screening / Immunization	No charge	30% coinsurance after deductible is met
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	30% coinsurance after deductible is met
<p><u>Virtual Care (Telemedicine / Telehealth Visits)</u></p> <p>Virtual Visits - Online visits with Doctors who also provide services in person</p> <p>Primary Care (PCP)</p> <p>Mental Health and Substance Abuse care</p> <p>Specialist</p>		
	0% coinsurance after deductible is met	30% coinsurance after deductible is met
	0% coinsurance after deductible is met	30% coinsurance after deductible is met
	0% coinsurance after deductible is met	30% coinsurance after deductible is met

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Questions: (833) 592-9956 or visit us at www.anthem.com

VA/LG/Anthem POS AdvantageOne HSA 3000/0%/4500 Rx \$10/\$40/\$70/20%/6F02/01-01-2022

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Medical Chats and Virtual (Video) Visits for Primary Care from our Online Provider K Health, through its affiliated Provider groups	0% coinsurance after deductible is met	
Virtual Visits from Online Provider LiveHealth Online via www.livehealthonline.com ; our mobile app, website or Anthem-enabled device		
Primary Care (PCP) and Mental Health and Substance Abuse	0% coinsurance after deductible is met	
Specialist Care	0% coinsurance after deductible is met	
<u>Visits in an Office</u>		
Primary Care (PCP)	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Specialist Care	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<u>Other Practitioner Visits</u>		
Routine Maternity Care (Prenatal and Postnatal)	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Retail Health Clinic	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Manipulation Therapy <i>Coverage is limited to 30 visits per benefit period.</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<u>Other Services in an Office</u>		
Allergy Testing	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Dialysis/Hemodialysis	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Prescription Drugs <i>Dispensed in the office</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Surgery	0% coinsurance after deductible is met	30% 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>Diagnostic Services</u> Lab Office Preferred Reference Lab Outpatient Hospital	0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met
X-Ray Office Outpatient Hospital	0% coinsurance after deductible is met 0% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met
<u>Advanced Diagnostic Imaging</u> <i>for example: MRI, PET and CAT scans</i> Office Outpatient Hospital	0% coinsurance after deductible is met 0% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met
<u>Emergency and Urgent Care</u> Urgent Care Emergency Room Facility Services Emergency Room Doctor and Other Services Ambulance	0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met	30% coinsurance after deductible is met Covered as In-Network Covered as In-Network Covered as In-Network
<u>Outpatient Mental Health and Substance Abuse</u> Doctor Office Visit Facility Visit Facility Fees	0% coinsurance after deductible is met 0% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Doctor Services	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<u>Outpatient Surgery</u> Facility Fees Hospital Freestanding Surgical Center Doctor and Other Services Hospital	 0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met	 30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met
<u>Hospital (Including Maternity, Mental Health and Substance Abuse)</u> Facility Fees Doctor and other services	 0% coinsurance after deductible is met 0% coinsurance after deductible is met	 30% coinsurance after deductible is met 30% coinsurance after deductible is met
<u>Recovery & Rehabilitation</u> Home Health Care <i>Coverage is limited to 100 visits per benefit period.</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Rehabilitation services <i>Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 60 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 60 visits per benefit period.</i> Office Outpatient Hospital	 0% coinsurance after deductible is met 0% coinsurance after deductible is met	 30% coinsurance after deductible is met 30% coinsurance after deductible is met
Cardiac rehabilitation <i>Coverage is limited to 36 visits per benefit period.</i> Office Outpatient Hospital	 0% coinsurance after deductible is met 0% coinsurance after deductible is met	 30% coinsurance after deductible is met 30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Skilled Nursing Care (facility) <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Inpatient Hospice	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Durable Medical Equipment	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Prosthetic Devices <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	0% coinsurance after deductible is met	30% coinsurance after 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	Combined with In-Network medical deductible	Combined with Non-Network medical deductible
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 <i>PreventiveRx Enhanced Drugs are covered 100% before deductible in-network. 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 Base Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies.</i>		
Home Delivery Pharmacy <i>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.</i>		
Tier 1 - Typically Generic <i>Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</i>	\$10 copay per prescription after deductible is met (retail) and \$25 copay per prescription after deductible is met (home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand <i>Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</i>	\$40 copay per prescription after deductible is met (retail) and \$100 copay per prescription after	30% coinsurance after deductible is met (retail) and Not covered (home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
	deductible is met (home delivery)	
Tier 3 - Typically Non-Preferred Brand <i>Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</i>	\$60 copay per prescription after deductible is met (retail) and \$150 copay per prescription after deductible is met (home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) <i>Per 30 day supply (specialty pharmacy).</i>	20% coinsurance up to \$250 per prescription after deductible is met (retail and home delivery)	30% coinsurance after 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
<i>This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.</i>		
<u>Children's Vision (up to age 19)</u> Child Vision Deductible	\$0 person	\$0 person
Vision exam <i>Limited to 1 exam per benefit period.</i>	No charge	Reimbursed Up to \$30
<u>Adult Vision (age 19 and older)</u> Adult Vision Deductible	\$0 person	\$0 person
Vision exam <i>Limited to 1 exam per benefit period.</i>	\$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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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。

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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.

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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): Dii naaltsoos biká'ígíí lahgo bina'ídiikidgo ná bohónéedzǫ́ dóó bee ahóót'i' t'áá ni nizaad k'ehǫ́ bee níl hodoonih t'áadoo bááh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih nínízingo kojí' hodiílnih (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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It's important we treat you fairly

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