

# Your summary of benefits



And Its Affiliate HealthKeepers, Inc.

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

Prince George County

Your Contract Code: Custom

07/01/2022 - 06/30/2023

Your Plan: Anthem POS AdvantageOne 30 500/30%/4000 Rx \$15/\$30/\$60/\$125

Your Network: HealthKeepers

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b>	\$500 person / \$1,000 family	\$1,000 person / \$2,000 family
<b>Out-of-Pocket Limit</b>	\$4,000 person / \$8000 family	\$6,250 person / \$12,500 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>		
<b>Preventive Care / Screening / Immunization</b>	No charge	30% coinsurance after medical deductible is met
<b>Preventive Care for Chronic Conditions</b> <i>per IRS guidelines</i>	No charge	30% coinsurance after medical deductible is met
<b><u>Virtual Care (Telemedicine / Telehealth Visits)</u></b>  <b>Virtual Visits - Online visits with Doctors who also provide services in person</b>  Primary Care (PCP)	<b><u>Preferred PCP</u></b> \$15 copay per visit medical deductible does not apply <b><u>PCP</u></b>	30% coinsurance after medical deductible is met

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

VA/LG/Anthem POS AdvantageOne 25 500/30%/4500 Rx \$10/\$40/\$70/20%/6EY3/01-01-2022

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Mental Health and Substance Abuse care	\$30 copay per visit medical deductible does not apply	
Specialist	\$15 copay per visit medical deductible does not apply  \$60 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met  30% coinsurance after medical deductible is met
<b>Medical Chats and Virtual (Video) Visits for Primary Care</b> from our Online Provider K Health, through its affiliated Provider groups	No charge	
<b>Virtual Visits from Online Provider LiveHealth Online</b> via <a href="http://www.livehealthonline.com">www.livehealthonline.com</a> ; our mobile app, website or Anthem-enabled device		
Primary Care (PCP) and Mental Health and Substance Abuse	\$5 copay per visit medical deductible does not apply	
Specialist Care	\$60 copay per visit medical deductible does not apply	
<b><u>Visits in an Office</u></b>		
<b>Primary Care (PCP)</b>	<b><u>Preferred PCP</u></b> \$15 copay per visit medical deductible does not apply <b><u>PCP</u></b> \$30 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
<b>Specialist Care</b>	\$60 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
<b><u>Other Practitioner Visits</u></b>		
<b>Routine Maternity Care</b> (Prenatal and Postnatal)	30% 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
<b>Retail Health Clinic</b>	\$30 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
<b>Manipulation Therapy</b> <i>Coverage is limited to 30 visits per benefit period.</i>	\$30 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
<b><u>Other Services in an Office</u></b>		
<b>Allergy Testing</b>	\$15 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
<b>Chemo/Radiation Therapy</b>	30% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
<b>Dialysis/Hemodialysis</b>	30% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
<b>Prescription Drugs</b> <i>Dispensed in the office</i>	30% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
<b>Surgery</b>	30% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
<b><u>Diagnostic Services</u></b>		
<b>Lab</b>		
Office	No charge	30% coinsurance after medical deductible is met
Preferred Reference Lab	No charge	30% coinsurance after medical deductible is met
Outpatient Hospital	30% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
<b>X-Ray</b>		
Office	30% 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
Outpatient Hospital	30% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
<b>Advanced Diagnostic Imaging</b> <i>for example: MRI, PET and CAT scans</i>		
Office	30% 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
<b><u>Emergency and Urgent Care</u></b>		
<b>Urgent Care</b>	\$30 PCP copay/ \$60 specialist copay per visit	30% coinsurance after medical deductible is met
<b>Emergency Room Facility Services</b>	30% coinsurance after medical deductible is met	Covered as In-Network
<b>Emergency Room Doctor and Other Services</b>	30% coinsurance after medical deductible is met	Covered as In-Network
<b>Ambulance</b>	30% coinsurance after medical deductible is met	Covered as In-Network
<b><u>Outpatient Mental Health and Substance Abuse</u></b>		
<b>Doctor Office Visit</b>	\$30 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
<b>Facility Visit</b>		
Facility Fees	30% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Doctor Services	30% 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
<b><u>Outpatient Surgery</u></b> <b>Facility Fees</b> Hospital  Freestanding Surgical Center  <b>Doctor and Other Services</b> Hospital	30% coinsurance after medical deductible is met  \$300 copay per visit medical deductible does not apply  30% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met  30% coinsurance after medical deductible is met  30% coinsurance after medical deductible is met
<b><u>Hospital (Including Maternity, Mental Health and Substance Abuse)</u></b>  <b>Facility Fees</b>  <b>Doctor and other services</b>	30% coinsurance after medical deductible is met  30% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met  30% coinsurance after medical deductible is met
<b><u>Recovery &amp; Rehabilitation</u></b> <b>Home Health Care</b> <i>Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.</i>	30% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
<b>Rehabilitation services</b> <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	\$25 copay per visit medical deductible does not apply  30% coinsurance after medical deductible is met	30% 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
<b>Cardiac rehabilitation</b> <i>Coverage is limited to 36 visits per benefit period.</i>  Office     Outpatient Hospital	30% coinsurance after medical deductible is met     30% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met     30% coinsurance after medical deductible is met
<b>Skilled Nursing Care (facility)</b> <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.</i>	30% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
<b>Inpatient Hospice</b>	30% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
<b>Durable Medical Equipment</b>	30% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
<b>Prosthetic Devices</b> <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	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
<b>Pharmacy Deductible</b>	Not applicable	Not applicable
<b>Pharmacy Out-of-Pocket Limit</b>	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
<b>Prescription Drug Coverage</b> <i>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>		
<b>Home Delivery Pharmacy</b> <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>		

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<b>Tier 1 - Typically Generic</b> <i>Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</i>	\$15 copay per prescription, deductible does not apply (retail) and \$38 copay per prescription, deductible does not apply (home delivery)	30% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
<b>Tier 2 – Typically Preferred Brand</b> <i>Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</i>	\$30 copay per prescription, deductible does not apply (retail) and \$75 copay per prescription, deductible does not apply (home delivery)	30% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
<b>Tier 3 - Typically Non-Preferred Brand</b> <i>Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</i>	\$60 copay per prescription, deductible does not apply (retail) and \$150 copay per prescription, deductible does not apply (home delivery)	30% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
<b>Tier 4 - Typically Specialty (brand and generic)</b> <i>Per 30 day supply (specialty pharmacy).</i>	\$125 copay per prescription, deductible does not apply (retail and home delivery)	30% coinsurance, 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
<i>This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.</i>		
<b><u>Children's Vision (up to age 19)</u></b> <b>Child Vision Deductible</b>	\$0 person	\$0 person
<b>Vision exam</b> <i>Limited to 1 exam per benefit period.</i>	No charge	Reimbursed Up to \$30
<b><u>Adult Vision (age 19 and older)</u></b> <b>Adult Vision Deductible</b>	\$0 person	\$0 person

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Vision exam</b> <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)

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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.

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### 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>.