# Your summary of benefits

And Its Affiliate HealthKeepers, Inc.

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

**Prince George County 07/01/2023 – 06/30/2024 Wellness Plan**

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

Your Network: KeyCare (out-of-state) and HealthKeepers (Virginia)

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|
| **Overall Deductible** | $500 person / $1,000 family | $1,000 person / $2,000 family |
| **Overall Out-of-Pocket Limit** | $4,000 person / $8,000 family | $6,250 person / $12,500 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.<br>Your copays, coinsurance and deductible count toward your out of pocket limit(s).<br>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 $0 copay per visit medical deductible does not apply; and $60 copay per visit medical deductible does not apply for covered Specialist Care.* | | |
| **Preferred PCP** *virtual and office* | $15 copay per visit medical deductible does not apply | Not covered |
| **Primary Care (PCP)** *virtual and office* | $30 copay per visit medical deductible does not apply | 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 |
|---|---|---|
| **Mental Health and Substance Abuse Care** *virtual and office* | $30 copay per visit medical deductible does not apply | 30% coinsurance after medical deductible is met |
| **Specialist Care** *virtual and office* | $60 copay per visit medical deductible does not apply | 30% coinsurance after medical deductible is met |
| **<u>Other Practitioner Visits</u>** | | |
| **Routine Maternity Care** (Prenatal and Postnatal) | 30% coinsurance after medical deductible is met | 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.* | $30 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.* | $30 copay per visit medical deductible does not apply | 30% coinsurance after medical deductible is met |
| **<u>Other Services in an Office</u>** | | |
| **Allergy Testing** | $15 copay per visit medical deductible does not apply | 30% coinsurance after medical deductible is met |
| **Prescription Drugs** *Dispensed in the office* | 30% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Surgery** | 30% coinsurance after medical deductible is met | 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 |
| **<u>Diagnostic Services</u>** **Lab** | | |
| Office | No charge | 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 |
|---|---|---|
| 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 |
| **X-Ray** | | |
| 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 |
| **Advanced Diagnostic Imaging** *for example: MRI, PET and CAT scans* | | |
| 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 |
| **Emergency and Urgent Care** | | |
| **Urgent Care** *includes doctor services. Additional charges may apply depending on the care provided.* | $30 PCP copay/ $60 specialist copay per visit medical deductible does not apply | 30% coinsurance after medical deductible is met |
| **Emergency Room Facility Services** | 30% coinsurance after medical deductible is met | Covered as In-Network |
| **Emergency Room Doctor and Other Services** | 30% coinsurance after medical deductible is met | Covered as In-Network |
| **Ambulance** | 30% coinsurance after medical deductible is met | Covered as In-Network |
| **Outpatient Mental Health and Substance Abuse Care at a Facility** | | |
| Facility Fees | 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 |
|---|---|---|
| Doctor Services | 30% coinsurance after medical deductible is met | 30% coinsurance after medical 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 | $300 copay per visit medical deductible does not apply | 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**<br>*Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.* | 30% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Rehabilitation and Habilitation services** *including physical, occupational and speech therapies.*<br>*Coverage for physical and occupational therapies is limited to 60 visits combined per benefit period. Coverage for speech therapy is limited to 60 visits per benefit period.* | | |
| Office | $25 copay per visit medical deductible does not apply | 30% coinsurance after medical deductible is met |
| Outpatient Hospital | 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 |
|---|---|---|
| **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*<br>*Coverage is limited to 36 visits per benefit period.* | 30% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Dialysis/Hemodialysis** *office and outpatient hospital* | 30% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Chemo/Radiation Therapy** *office and outpatient hospital* | 30% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Skilled Nursing Care (facility)**<br>*Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.* | 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** | 30% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Prosthetic Devices**<br>*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** | Not applicable | Not applicable |
| **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:** ***PreventiveRx Enhanced Drugs are covered at 100% with no deductible***<br>**Network:** ***Base Network***<br>**Drug List:** ***Essential*** *Drugs not included on the Essential drug list will not be covered.* | | |
| **Day Supply Limits:** | | |

| Covered Prescription Drug Benefits | Cost if you use an In-Network Pharmacy | Cost if you use a Non-Network Pharmacy |
|---|---|---|
| **Retail Pharmacy** *30 day supply (cost shares noted below)*<br>**Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).*<br>**Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail (IngenioRx will become CarelonRx on January 1, 2023). You will need to call us on the number on your ID card to sign up when you first use the service.*<br>**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**<br>*Deductible does not apply for In and Non-Network* | $15 copay per prescription (retail) and $38 copay per prescription (home delivery) | 30% coinsurance (retail) and Not covered (home delivery) |
| **Tier 2 – Typically Preferred Brand**<br>*Deductible does not apply for In and Non-Network* | $30 copay per prescription (retail) and $75 copay per prescription (home delivery) | 30% coinsurance (retail) and Not covered (home delivery) |
| **Tier 3 - Typically Non-Preferred Brand**<br>*Deductible does not apply for In and Non-Network* | $60 copay per prescription (retail) and $150 copay per prescription (home delivery) | 30% coinsurance (retail) and Not covered (home delivery) |
| **Tier 4 - Typically Specialty (brand and generic)**<br>*Deductible does not apply for In and Non-Network* | $125 copay per prescription (retail and home delivery) | 30% coinsurance (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)**<br>*Limited to 1 exam per benefit period.* | No charge | Reimbursed Up to $30 |
| **Adult Vision exam (age 19 and older)**<br>*Limited to 1 exam per benefit period.* | $15 copay | Reimbursed Up to $30 |

**Notes:**

- 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.
- The representations of benefits in this document are subject to Virginia Bureau of Insurance (BOI) approval and are subject to change.

*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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## 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)**

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## Language Access Services:

**Navajo (Diné):** Díí naaltsoos biká'ígíí łahgo bína'ídíłkidgo ná bohónéedzą́ dóó bee ahóót'i' t'áá ni nizaad k'ehjį bee nił hodoonih t'áadoo bą́ąh ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínízingo kojį' hodíílnih (833) 592-9956.

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