Your summary of benefits

Anthem® HealthKeepers Inc.

Your Contract Code: 365D (Custom)

Your Plan: Anthem HealthKeepers POS OA 15/20%/3500 Rx $15/$50/$85/20%

Your Network: HealthKeepers

UVA Physicians

07/01/2023 – 06/30/2024

Covered Medical Benefits	Cost if you use the UPG/UVA Network	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$750 person / $1,500 family		$750 person / $1,500 family
Out-of-Pocket Limit	$5,000 person / $10,000 family		$5,000person / $10,000 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. Your copays, coinsurance and deductible count toward your out of pocket amount(s). In-network and out-of-network out-of-pocket maximum amounts are separate and do not accumulate toward each other.			
Preventive Care / Screening / Immunization	No charge	No charge	30% coinsurance after medical deductible is met
<u>Virtual Care (Telemedicine/Telehealth Visits)</u> **Virtual Visits – Online visits with Doctors who also provide services in person**			
Primary Care (PCP)	$15 copay per visit	$20 copay per visit	30% coinsurance after medical deductible is met
Mental Health and Substance Abuse Care	$15 copay per visit	$20 copay per visit	30% coinsurance after medical deductible is met
Specialist	$30 copay per visit	$35 copay per visit	30% coinsurance after medical deductible is met

Medical Chats and Virtual (Video) Visits for Primary Care from our Online Provider K Health, through its affiliated provider groups	No charge	No charge	Not applicable
Virtual Visits from Online Provider LiveHealth Online *Via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*			
Primary Care (PCP)	$15 copay per visit	$20 copay per visit	Not applicable
Mental Health and Substance Abuse	$0 copay per visit	$0 copay per visit	Not applicable
Specialist	$30 copay per visit	$35 copay per visit	Not applicable
Visits in an office			
Primary Care (PCP)	$15 copay per visit	$20 copay per visit	30% coinsurance after medical deductible is met
Specialist Care	$30 copay per visit	$35 copay per visit	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use the UPG/UVA Network	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	$20 copay per visit	30% coinsurance after medical deductible is met
Routine Maternity Care (Prenatal and Postnatal)	No charge	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Manipulation Therapy *Coverage is limited to 30 visits per benefit period.*	$25 copay per visit	$25 copay per visit	30% coinsurance after medical deductible is met
Other Services in an Office:			
Allergy Testing	$15 copay per visit	$20 copay per visit	30% coinsurance after medical deductible is met
Chemo/Radiation Therapy	No charge	No charge	30% coinsurance after medical deductible is met
Dialysis/Hemodialysis	$30 copay per visit	$35 copay per visit	30% coinsurance after medical deductible is met
Prescription Drugs - *Dispensed in the office*	20% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Surgery	$30 copay per surgery	$35 copay per surgery	30% coinsurance after medical deductible is met
Diagnostic Services **Lab:**			
Office	No charge	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Preferred Reference Lab	No charge	No charge	30% coinsurance after medical deductible is met
Outpatient Hospital	No charge	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use the UPG/UVA Network	Cost if you use an In- Network Provider	Cost if you use a Non-Network Provider
X-Ray:			
Office	No charge	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Outpatient Hospital *Including Freestanding Radiology Centers*	No charge	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Advanced Diagnostic Imaging:			
Office	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Outpatient Hospital *Including Freestanding Radiology Centers*	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Emergency and Urgent Care			
Urgent Care	$15 PCP /$30 SPC copay per visit	$20 PCP /$35 SPC copay per visit	30% coinsurance after medical deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$300 copay per visit	$300 copay per visit	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	No charge	Covered as In-Network
Ambulance	$100 copay per transport	$100 copay per transport	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse **Doctor Office Visit**	No charge	No charge	30% coinsurance after medical deductible is met
Facility Fees	No charge	No charge	30% coinsurance after medical deductible is met
Doctor Services	No charge	No charge	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use the UPG/UVA Network	Cost if you use an In- Network Provider	Cost if you use a Non-Network Provider
Outpatient Surgery			
Facility Fees:			
Hospital	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Freestanding Surgical Center	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	30% coinsurance after deductible is met
Doctor and other services			
Hospital	$30 copay per visit	$35 copay per visit	30% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):			
Facility Fees (including Maternity)	$300 copay per admission	$600 copay per admission	30% coinsurance after medical deductible is met
Facility Fees for Mental / Behavioral Health, Substance	$300 copay per admission	$300 copay per admission	30% coinsurance after medical deductible is met
Doctor and other services	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	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 after medical deductible is met	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is

Covered Medical Benefits	Cost if you use the UPG/UVA Network	Cost if you use an In- Network Provider	Cost if you use a Non-Network Provider
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.	$30 copay per visit	$30 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.	$30 copay per visit	$30 copay per visit	30% coinsurance after medical deductible is met
Cardiac rehabilitation Office *Coverage is limited to 36 visits per benefit period.*	$30 copay per visit	$35 copay per visit	30% coinsurance after medical deductible is met
Outpatient Hospital *Coverage is limited to 36 visits per benefit period.*	$30 copay per visit	$35 copay per visit	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 after medical deductible is met	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Hospice	20% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Durable Medical Equipment	20% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Prosthetic Devices	30% coinsurance after medical deductible is met	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 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 *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 (National) network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies. Enhanced Preventive Rx Drug List covered at in-network 100% before deductible, out-of-network covered at 30% coinsurance deductible does not apply.*		
Home Delivery Pharmacy *Maintenance medication are available through CarelonRx 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. Home Delivery is an optional service on this plan.*		
Tier 1 - Typically Generic *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$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)
Tier 2 – Typically Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$50 copay per prescription, deductible does not apply (retail) and $125 copay per prescription, deductible does not apply (home delivery)	30% coinsurance, 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).*	$85 copay per prescription, deductible does not apply (retail) and $213 copay per prescription, deductible does not apply (home delivery)	30% coinsurance, 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)	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
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。

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(833) 592-9956로 문의하십시오.

Language Access Services:

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

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (833) 592-9956 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) 592-9956.

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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) 592-9956.

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.