

# HealthKeepers, Inc.

## Anthem HealthKeepers Platinum OAPOS 10/10%/2500

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 03/01/2015 – 02/29/2016

Coverage for: Individual + Family | Plan Type: POS



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.anthem.com/sbc](http://www.anthem.com/sbc) or by calling (855) 330-1214.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	<b>\$2,000</b> person / <b>\$4,000</b> family for Out-of-Network Providers. Does not apply to Prescription Drugs.	You must pay all costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes; <b>\$2,500</b> person / <b>\$5,000</b> family for In-Network Providers. <b>\$5,000</b> person / <b>\$10,000</b> family for Out-of-Network Providers.	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, Balance-Billed charges, and Health Care This Plan Doesn't Cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes, HealthKeepers. For a list of In-Network providers, see <a href="http://www.anthem.com">www.anthem.com</a> or call (855) 330-1214. Dental and Vision benefits may access a different network of providers.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 3 for how this plan pays different kinds of <u>providers</u> .

**Questions:** Call (855) 330-1214 or visit us at [www.anthem.com](http://www.anthem.com)

VA/S/F/Anthem HealthKeepers Platinum OAPOS 10/1/1NBR/NA/01-15

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call (855) 330-1214 to request a copy.

Important Questions	Answers	Why this Matters:
<b>Do I need a referral to see a <u>specialist</u>?</b>	No; You do not need a referral to see a specialist.	You can see the <b><u>specialist</u></b> you choose without permission from this plan.
<b>Are there services this plan doesn't cover?</b>	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about <b><u>excluded services</u></b> .



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **In-Network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$10 copay per visit	30% coinsurance	-----none-----
	Specialist visit	\$20 copay per visit	30% coinsurance	-----none-----
	Other practitioner office visit	<u>Chiropractor</u> \$10 copay per visit <u>Acupuncture</u> Not covered	<u>Chiropractor</u> 30% coinsurance <u>Acupuncture</u> Not covered	<u>Chiropractor</u> Coverage for In-Network Providers and Non-Network Providers combined is limited to 30 visits per benefit period. <u>Acupuncture</u> -----none-----
	Preventive care/screening/immunization	No charge	30% coinsurance	-----none-----
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	<u>Lab – Office</u> No charge <u>X-Ray – Office</u> 10% coinsurance	<u>Lab – Office</u> 30% coinsurance <u>X-Ray – Office</u> 30% coinsurance	<u>Lab – Office</u> -----none----- <u>X-Ray – Office</u> -----none-----
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	-----none-----
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.anthem.com/pharmacyinfor">http://www.anthem.com/pharmacyinfor</a>	Tier 1 - Typically Generic	\$10 copay per prescription (retail only) and \$25 copay per prescription (home delivery only)	30% coinsurance (retail and home delivery)	Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs.
	Tier 2 - Typically Preferred/Formulary Brand	\$30 copay per prescription (retail only) and \$75 copay per prescription	30% coinsurance (retail and home delivery)	Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs. If

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
<a href="#">mation/</a> Anthem National Drug List 4 Tier		(home delivery only)		you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.
	Tier 3 - Typically Non-preferred/Non-formulary and Specialty Drugs	\$60 copay per prescription (retail only) and \$150 copay per prescription (home delivery only)	30% coinsurance (retail and home delivery)	Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.
	Tier 4 - Typically Specialty Drugs	25% coinsurance up to \$250 (retail only) and 25% coinsurance up to \$625 (home delivery only)	30% coinsurance (retail and home delivery)	Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program). No coverage for non-formulary drugs. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$150 copay per admission	30% coinsurance	-----none-----
	Physician/surgeon fees	10% coinsurance	30% coinsurance	-----none-----
<b>If you need immediate medical attention</b>	Emergency room services	\$150 copay per visit	Covered as In-Network	Copay waived if admitted.
	Emergency medical transportation	10% coinsurance	Covered as In-Network	-----none-----
	Urgent care	\$20 copay per visit	30% coinsurance	-----none-----
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$250 copay per day up to \$750 per admission	30% coinsurance	Coverage for Inpatient rehabilitation and skilled nursing services combined In-Network Providers and Non-Network Providers combined is limited to 100 days per admission.
	Physician/surgeon fee	10% coinsurance	30% coinsurance	-----none-----
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	<u>Mental/Behavioral Health Office Visit</u> \$10 copay per visit <u>Mental/Behavioral Health Facility Visit-</u>	<u>Mental/Behavioral Health Office Visit</u> 30% coinsurance <u>Mental/Behavioral Health Facility Visit-</u>	<u>Mental/Behavioral Health Office Visit</u> -----none----- <u>Mental/Behavioral Health Facility Visit-Facility Charges</u>

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
		<u>Facility Charges</u> \$150 copay per admission	<u>Facility Charges</u> 30% coinsurance	-----none-----
	Mental/Behavioral health inpatient services	\$250 copay per day up to \$750 per admission	30% coinsurance	-----none-----
	Substance use disorder outpatient services	<u>Substance Abuse Office Visit</u> \$10 copay per visit <u>Substance Abuse Facility Visit -Facility Charges</u> \$150 copay per admission	<u>Substance Abuse Office Visit</u> 30% coinsurance <u>Substance Abuse Facility Visit -Facility Charges</u> 30% coinsurance	<u>Substance Abuse Office Visit</u> -----none----- <u>Substance Abuse Facility Visit -Facility Charges</u> -----none-----
	Substance use disorder inpatient services	\$250 copay per day up to \$750 per admission	30% coinsurance	-----none-----
<b>If you are pregnant</b>	Prenatal and postnatal care	\$150 copay per visit	30% coinsurance	-----none-----
	Delivery and all inpatient services	\$250 copay per day up to \$750 per admission	30% coinsurance	Applies to inpatient facility. Other cost shares may apply depending on services provided.
<b>If you need help recovering or have other special health needs</b>	Home health care	\$10 copay per visit	30% coinsurance	Coverage for In-Network Providers and Non-Network Providers combined is limited to 100 visits per benefit period.
	Rehabilitation services	\$10 copay per visit	30% coinsurance	Coverage for Speech Therapy is limited to 30 visits per benefit period and physical therapy and occupational therapy combined is limited to 30 visits per benefit period. Apply to In-Network Providers and Non-Network Providers combined.
	Habilitation services	\$10 copay per visit	30% coinsurance	Habilitation and Rehabilitation visits count towards your Rehabilitation limit.
	Skilled nursing care	\$250 copay per day up to \$750 per admission	30% coinsurance	Coverage for Inpatient rehabilitation and skilled nursing services combined In-Network Providers and Non-

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
				Network Providers combined is limited to 100 days per admission.
	Durable medical equipment	10% coinsurance	30% coinsurance	-----none-----
	Hospice service	No charge	30% coinsurance	-----none-----
<b>If your child needs dental or eye care</b>	Eye exam	No charge	No charge	Coverage for In-Network Providers and Non-Network Providers combined is limited to 1 exam per benefit period. Coverage for Non-Network Providers is limited to \$30 maximum benefit per visit.
	Glasses	No charge	No charge	Coverage for In-Network Providers and Non-Network Providers combined is limited to 1 unit per benefit period. Coverage for bifocal lenses is limited to \$40 maximum benefit per occurrence, single vision lenses is limited to \$25 maximum benefit per occurrence, trifocal lenses is limited to \$55 maximum benefit per occurrence, and frames is limited to \$45 maximum benefit per occurrence. Apply to Non-Network Providers.
	Dental check-up	10% coinsurance	30% coinsurance	Frequencies and limitations for this service may vary.

## Excluded Services & Other Covered Services:

### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-Formulary drugs
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

### Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care Coverage is limited to 30 visits per benefit period.
- Most coverage provided outside the United States. See [www.bcbs.com/bluecardworldwide](http://www.bcbs.com/bluecardworldwide).
- Private-duty nursing Coverage is limited to 16 hours per benefit period.

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at (855) 330-1214. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

ATTN: Grievances and Appeals  
P.O. Box 27401  
Richmond, VA 23279

Department of Labor's Employee  
Benefits Security Administration  
(866) 444-EBSA (3272)  
[www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

Virginia Bureau of Insurance  
1300 East Main Street  
P. O. Box 1157  
Richmond, VA 23218  
(800) 552-7945

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoolwol ínízinigo t'áá diné k'éjígoo, t'áá shoodí ba na'alníhí ya sidáhí bich'í naabídíílkíid. Eí doo biigha daago ni ba'nija'go ho'aalagí bich'í hodiilní. Hai'daa iini'taago eíya, t'áá shoodí diné ya atáh halne'ígú ní béesh bee hane'í wólta' bi'ki si'niilígú bi'kéhgo bich'í hodiilní.

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card..

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*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

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## About These Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$6,740
- Patient pays \$800

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$0
Copays	\$700
Coinsurance	\$100
Limits or exclusions	\$0
<b>Total</b>	<b>\$800</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,070
- Patient pays \$1,330

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$0
Copays	\$1,300
Coinsurance	\$30
Limits or exclusions	\$0
<b>Total</b>	<b>\$1,330</b>

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

**\*No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

**\*No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

**✓Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

**✓Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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