

# Your summary of benefits



## Anthem HealthKeepers

Anthem® HealthKeepers Inc.

UVA Physicians

Your Contract Code: Custom

07/01/2024-06/30/2025

Your Plan: Anthem HealthKeepers OA HSA 2000NE/10%/4725 Rx \$10/\$40/\$70/20%

Your Network: HealthKeepers

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
<b>Primary Care, and medical services for urgent/acute care</b>	No charge after deductible is met
<b>Mental Health &amp; Substance Use Disorder Services</b>	No charge after deductible is met
<b>Specialist care</b>	10% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b>	\$2,000 person / \$4,000 family	\$4,000 person / \$8,000 family
<b>Overall Out-of-Pocket Limit</b>	\$4,725 person / \$9,450 family	\$9,450 person / \$18,900 family

The family deductible and out-of-pocket limit are non-embedded, meaning the cost shares of all family members apply to one family deductible and one family out-of-pocket limit. The per person deductible and per person out-of-pocket limit apply to individuals enrolled under single-only coverage.

All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit (excluding Non-Network Human Organ and Tissue Transplant (HOTT), Cellular and Gene Therapy services).

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).*

<b>Primary Care (PCP) and Mental Health and Substance Use Disorder Services</b> <i>virtual and office</i>	10% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Specialist Care</b> <i>virtual and office</i>	10% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Other Practitioner Visits</b>		
<b>Routine Maternity Care</b> (Prenatal and Postnatal)	10% 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
<b>Retail Health Clinic</b> <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i>	10% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Manipulation Therapy</b> <i>Coverage is limited to 30 visits per benefit period.</i>	10% coinsurance after deductible is met	30% coinsurance after deductible is met
<u><b>Other Services in an Office</b></u> <b>Allergy Testing</b>  <b>Prescription Drugs</b> <i>Dispensed in the office</i>  <b>Surgery</b>	10% coinsurance after deductible is met  10% coinsurance after deductible is met  10% coinsurance after deductible is met	30% coinsurance after deductible is met  30% coinsurance after deductible is met  30% coinsurance after deductible is met
<b>Preventive care / screenings / immunizations</b>	No charge	30% coinsurance after deductible is met
<b>Preventive Care for Chronic Conditions</b> <i>per IRS guidelines</i>	No charge	30% coinsurance after deductible is met
<u><b>Diagnostic Services</b></u> <b>Lab</b> Office  Preferred Reference Lab  Non-Preferred Lab  Outpatient Hospital	10% coinsurance after deductible is met  10% coinsurance after deductible is met  Not Covered  10% coinsurance after deductible is met	30% coinsurance after deductible is met  30% coinsurance after deductible is met  30% coinsurance after deductible is met  30% coinsurance after deductible is met
<b>X-Ray</b> Office  Outpatient Hospital	10% coinsurance after deductible is met  10% coinsurance after deductible is met	30% coinsurance after deductible is met  30% coinsurance after deductible is met

<b>Advanced Diagnostic Imaging</b> <i>for example: MRI, PET and CAT scans</i>		
Office	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	10% 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
<b><u>Emergency and Urgent Care</u></b>		
<b>Urgent Care</b>	10% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Emergency Room Facility Services</b>	10% coinsurance after deductible is met	Covered as In-Network
<b>Emergency Room Doctor and Other Services</b>	10% coinsurance after deductible is met	Covered as In-Network
<b>Ambulance</b>	10% coinsurance after deductible is met	Covered as In-Network
<b><u>Outpatient Mental Health and Substance Use Disorder Services at a Facility</u></b>		
Facility Fees	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor Services	10% coinsurance after deductible is met	30% coinsurance after deductible is met
<b><u>Outpatient Surgery</u></b>		
<b>Facility Fees</b>		
Hospital	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Ambulatory Surgical Center	10% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Physician and other services</b> <i>including surgeon fees</i>		
Hospital	10% coinsurance after deductible is met	30% coinsurance after deductible is met

<b><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u></b>		
<b>Facility Fees</b>	10% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Physician and other services</b> <i>including surgeon fees</i>	10% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Home Health Care</b> <i>Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.</i>	10% coinsurance after deductible is met	30% coinsurance after deductible is met

<b>Covered Medical Benefits</b>	<b>Cost if you use an In-Network Provider</b>	<b>Cost if you use a Non-Network Provider</b>
<b>Rehabilitation and Habilitation services</b> <i>including physical, occupational and speech therapies.</i> <i>Coverage for physical and occupational therapies is limited to 30 visits combined per benefit period. Coverage for speech therapy is limited to 30 visits per benefit period.</i>		
Office	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Pulmonary rehabilitation</b> <i>office and outpatient hospital</i>	10% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Cardiac rehabilitation</b> <i>office and outpatient hospital</i> <i>Coverage is limited to 36 visits per benefit period.</i>	10% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Dialysis/Hemodialysis</b> <i>office and outpatient hospital</i>	10% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Chemo/Radiation Therapy</b> <i>office and outpatient hospital</i>	10% coinsurance after deductible is met	30% coinsurance after 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>	10% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Inpatient Hospice</b>	10% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Durable Medical Equipment</b>	10% coinsurance after deductible is met	30% coinsurance after deductible is met

<b>Prosthetic Devices</b> <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	10% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Covered Prescription Drug Benefits</b>	<b>Cost if you use an In-Network Pharmacy</b>	<b>Cost if you use a Non-Network Pharmacy</b>
<b>Pharmacy Deductible</b>	Combined with In-Network medical deductible	Combined with Non-Network medical deductible
<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>Covered Prescription Drug Benefits</b>	<b>Cost if you use an In-Network Pharmacy</b>	<b>Cost if you use a Non-Network Pharmacy</b>
<b>Prescription Drug Coverage</b> <b>Network: <i>Base (National) Network</i></b> <b>Drug List: <i>Essential</i></b> <i>Drugs not included on the Essential drug list will not be covered.</i>		
<b>Day Supply Limits:</b> <b>Retail Pharmacy</b> <i>30 day supply (cost shares noted below)</i> <b>Retail 90 Pharmacy</b> <i>90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).</i> <b>Home Delivery Pharmacy</b> <i>90 day supply (maximum cost shares noted below). Maintenance medications are available through CarelonRx Pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.</i> <b>Specialty Pharmacy</b> <i>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.</i>		
<b>Tier 1 - Typically Generic</b>	\$10 copay per prescription after deductible is met (retail) and \$20 copay per prescription after deductible is met (home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)
<b>Tier 2 – Typically Preferred Brand</b>	\$40 copay per prescription after deductible is met (retail) and \$100 copay per prescription after deductible is met (home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)

<b>Tier 3 - Typically Non-Preferred Brand</b>	\$70 copay per prescription after deductible is met (retail) and \$175 copay per prescription after deductible is met (home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)
<b>Tier 4 - Typically Specialty (brand and generic)</b>	20% coinsurance up to \$300 per prescription after deductible is met (retail and home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)

<b>Covered Vision Benefits</b>	<b>Cost if you use an In-Network Provider</b>	<b>Cost if you use a Non-Network Provider</b>
<i>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.</i>		
<b>Children's Vision exam (up to age 19)</b> <i>Limited to 1 exam per benefit period.</i>	No charge	\$0 copayment up to plan's Maximum Allowed Amount
<b>Adult Vision exam (age 19 and older)</b> <i>Limited to 1 exam per benefit period.</i>	\$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 limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
- 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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Questions: (833) 592-9956 or visit us at [www.anthem.com](http://www.anthem.com)



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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 (فارسی):** 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.

**Navajo (Diné):** Dii naaltsoos biká'ígíí lahgo bina'ídiikidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj'í bee nił hodoonih t'áadoo báąh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih nínizingo koj' hodiilnih (833) 592-9956.

## Language Access Services:

**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 ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਬਾਸ਼ੀਏ 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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### 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>.