

Your summary of benefits

Anthem® HealthKeepers Inc.

Your Contract Code: Custom

Your Plan: Williamsburg - James City County Public Schools HealthKeepers HSA 3300

Your Network: HealthKeepers

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge after deductible is met
Mental Health & Substance Use Disorder Services	No charge after deductible is met
Specialist care	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	\$3,300 person / \$6,600 family	
Overall Out-of-Pocket Limit	\$5,000 person / \$10,000 family	\$10,000 person / \$20,000 family
<p>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.</p> <p>All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit (excluding Out-of-Network Human Organ and Tissue Transplant (HOTT), Cellular and Gene Therapy services).</p> <p>In-Network and Out-of-Network deductibles and out-of-pocket limit amounts are combined and accumulate toward each other.</p>		
Doctor Visits (virtual and office) <i>You are encouraged to select a Primary Care Physician (PCP).</i>		
Primary Care (PCP) and Mental Health and Substance Use Disorder Services <i>virtual and office</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Specialist Care <i>virtual and office</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Other Practitioner Visits		
Maternity Doctor services (prenatal/postnatal care and delivery)	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Manipulation Therapy <i>Coverage is limited to 30 visits per benefit period.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<u>Other Services in an Office</u>		
Allergy Testing	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prescription Drugs <i>Dispensed in the office</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Surgery	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	40% coinsurance after deductible is met
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	40% coinsurance after deductible is met
<u>Diagnostic Services</u>		
Lab		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Reference Lab	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
X-Ray		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i>		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<u>Emergency and Urgent Care</u>		
Urgent Care	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Emergency Room Facility Services	20% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	Covered as In-Network
Ambulance	20% coinsurance after deductible is met	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Mental Health and Substance Use Disorder Services at a Facility Facility Fees Doctor Services	20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met
<u>Outpatient Surgery</u> Facility Fees Hospital Ambulatory Surgical Center Physician and other services <i>including surgeon fees</i> Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met
<u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u> Facility Fees Physician and other services <i>including surgeon fees</i>	20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met
Home Health Care <i>Coverage is limited to 90 visits per benefit period. Limits are combined for all home health services.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies.</i> Office Outpatient Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met
Pulmonary rehabilitation <i>office and outpatient hospital</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Cardiac rehabilitation <i>office and outpatient hospital</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Dialysis/Hemodialysis <i>office and outpatient hospital</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Chemo/Radiation Therapy <i>office and outpatient hospital</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Skilled Nursing Care (facility) <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 180 days combined per benefit period.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Inpatient Hospice	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Durable Medical Equipment	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prosthetic Devices <i>Coverage for wigs is limited to 3 per benefit period after treatment for a covered medical benefit that causes hair loss.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with Out-of-Network medical deductible
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Out-of-Network medical out-of-pocket limit
Prescription Drug Coverage Network: <i>Base Network</i> Drug List: <i>National Direct Plus</i> <i>Drugs not included on the National Direct Plus drug list will not be covered.</i>		
Day Supply Limits: Retail Pharmacy 30 day supply (cost shares noted below) Retail 90 Pharmacy 90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies). Home Delivery Pharmacy 90 day supply (maximum cost shares noted below). Maintenance medications are available through our 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. 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	20% coinsurance after deductible is met (retail and home delivery)	20% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 - Typically Preferred Brand and Non-Preferred Generic Drugs	20% coinsurance after deductible is met (retail and home delivery)	20% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand & Specialty Drugs	20% coinsurance after deductible is met (retail and home delivery)	20% coinsurance after deductible is met (retail) and Not covered (home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<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>		
Children's Vision exam (up to age 19) <i>Limited to 1 exam per benefit period.</i>	No charge	\$0 copayment up to plan's Maximum Allowed Amount
Adult Vision exam (age 19 and older) <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 representations of benefits in this document are subject to Virginia Bureau of Insurance (BOI) approval and are subject to change
- Continuous Glucose Monitors are only covered under the Pharmacy benefit and not the Medical benefit.

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

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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)

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:

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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): Díí naaltsoos biká'ígíí lahgo bina'ídiłkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj bee níl hodoonih t'áadoo báąh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih nínízingo koj' hodiłnih (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.

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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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