

# Your summary of benefits



**Anthem** HealthKeepers

Anthem® HealthKeepers Inc.

Your Plan: Virginia Private Colleges: Plan 8 HMO HRA Open Access (Embedded Deductible)

Your Network: HealthKeepers

This Schedule provides just a summary of the Covered Expenses, Limitations and Exclusions under the Plan. All benefits below are subject to the Plan's terms and conditions, including Deductibles, Coinsurance, In Network discounts and Allowable Charges, as set forth in the Plan Document to which this Schedule is attached. Please read this Schedule only in conjunction with the Plan Document.

Benefits payable by the Plan may change depending upon whether Covered Services are obtained from a Participating Provider. The list of Participating Providers may change from time to time. A list of Participating Providers is located at <http://www.anthem.com>. Therefore, it is important to verify that the Provider who is treating you is currently a Participating Provider.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b>	\$3,400 person / \$6,800 family	\$3,400 person / \$6,800 family
<b>Out-of-Pocket Limit</b>	\$4,000 person / \$8,000 family	\$5,000 person / \$10,000 family
<p>The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per person 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 per person deductible or per person out-of-pocket maximum.</p> <p>Your copays, coinsurance and deductible count toward your out of pocket amount(s).</p> <p>In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other.</p>		
<b>Preventive Care / Screening / Immunization</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
<p><b><u>Virtual Care (Telemedicine / Telehealth Visits)</u></b></p> <p><b>Virtual Visits - Online visits with Doctors who also provide services in person</b></p>		
Primary Care (PCP)	0% coinsurance after deductible is met	30% coinsurance after deductible is met

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VA/LG/Virginia Private Colleges: Plan 8 HMO HRA (Embedded Deductible)/480Z/01-01-2026

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  Specialist	0% coinsurance after deductible is met	30% coinsurance after deductible is met
	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Video Visits with Live Health Online</b> via the Sydney mobile app or on Anthem.com  Primary Care (PCP) and Mental Health and Substance Abuse  Specialist Care	0% coinsurance after deductible is met	0% coinsurance after deductible is met
<b><u>Visits in an Office</u></b>  <b>Primary Care (PCP)</b>  <b>Specialist Care</b>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b><u>Other Practitioner Visits</u></b>  <b>Routine Maternity Care</b> (Prenatal and Postnatal)  <b>Retail Health Clinic</b>  <b>Manipulation Therapy</b> <i>Coverage is limited to 30 visits per benefit period.</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
	0% coinsurance after deductible is met	30% coinsurance after deductible is met
	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b><u>Other Services in an Office</u></b>  <b>Allergy Testing</b>  <b>Chemo/Radiation Therapy</b>  <b>Dialysis/Hemodialysis</b>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
	0% coinsurance after deductible is met	30% coinsurance after deductible is met
	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Prescription Drugs</b> <i>Dispensed in the office</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Surgery</b>	0% 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
<p><b><u>Diagnostic Services</u></b>  <b>Lab</b></p> <p>Office</p> <p>Preferred Reference Lab</p> <p>Outpatient Hospital</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><b>X-Ray</b></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><b>Advanced Diagnostic Imaging</b> <i>for example: MRI, PET and CAT scans</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><b><u>Emergency and Urgent Care</u></b></p> <p><b>Urgent Care</b></p> <p><b>Emergency Room Facility Services</b></p> <p><b>Emergency Room Doctor and Other Services</b></p> <p><b>Ambulance</b></p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><b><u>Outpatient Mental Health and Substance Abuse</u></b></p> <p><b>Doctor Office Visit</b></p>	<p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p><b>Facility Visit</b></p> <p>Facility Fees</p>	<p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Doctor Services	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<p><b><u>Outpatient Surgery</u></b></p> <p><b>Facility Fees</b></p> <p>Hospital</p> <p>Freestanding Surgical Center</p> <p><b>Doctor and Other Services</b></p> <p>Hospital</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><b><u>Hospital (Including Maternity, Mental Health and Substance Abuse)</u></b></p> <p><b>Facility Fees</b></p> <p><b>Doctor and other services</b></p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><b><u>Recovery &amp; Rehabilitation</u></b></p> <p><b>Home Health Care</b>  <i>Coverage is limited to 90 visits per benefit period. Limits are combined for all home health services.</i></p>	<p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p><b>Rehabilitation services</b>  <i>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.</i></p> <p>Office</p>	<p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p>Outpatient Hospital</p>	<p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>Cardiac rehabilitation</b>  <i>Coverage for cardiac rehabilitation is unlimited visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings</i></p> <p>Office</p>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<p>Outpatient Hospital</p>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<p><b>Skilled Nursing Care (facility)</b>  <i>Coverage is limited to 100 days per admission. Limit is combined In-Network and Non-Network.</i></p>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<p><b>Hospice</b></p>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<p><b>Durable Medical Equipment</b></p>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<p><b>Prosthetic Devices</b>  <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period. Limit is combined In-Network and Non-Network.</i></p>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<p><b>Hearing Aids</b>  <i>One hearing aid per hearing impaired ear per 36 months, for adults and children, includes wearable and bone anchored hearing aids. \$2,500 benefit maximum.</i></p>	0% coinsurance after deductible is met	40% coinsurance after deductible is met
<p><b>Autism Spectrum Disorder (ASD)</b>            Therapeutic Care: unlimited physical, occupational and speech Therapy</p> <p>Applied Behavioral Analysis</p>	<p><b>0%</b> of the amount the health care professionals in our network have agreed to accept for their services</p> <p><b>0%</b> of the amount the health care professionals in our network have agreed to accept for their services</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<b>Pharmacy Deductible</b>	Combined with In-Network medical deductible	Combined with out of Network medical deductible
<b>Pharmacy Out-of-Pocket Limit</b>	Combined with In-Network medical out-of-pocket limit	Not covered
<p><b>Prescription Drug Coverage</b> Cost shares for drugs included on the Essential Direct drug list appear below. Your plan uses the Advantage Network. You may receive up to a 90 day supply of medication at Rx Maintenance 90 pharmacies. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply. Drug cost share assistance programs may be available for certain specialty drugs.</p>		
<p><b>Home Delivery Pharmacy</b> 90 day supply (maximum cost shares noted below). Maintenance medications are available through CarelonRx Mail or at a participating Rx Maintenance 90 pharmacies. You may get two 30 day supply fills of the same maintenance medication at a retail pharmacy. Prior to your 3rd fill, you must switch to home delivery.</p>		
<p><b>Preventive Drugs</b> No deductible, copayment or coinsurance for In-Network drugs included on the VPCBC Preventive Rx drug list, a designated list of drugs for the treatment of diabetes, asthma, depression, heart health, high blood pressure, high cholesterol, and osteoporosis. The list is free of charge and is not subject to the deductible.</p>		
<p><b>Tier 1 Preventive - Typically Generic</b>  <i>Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).</i>  <i>Per 90 day supply (home delivery).</i></p> <p><b>Tier 2 Preventive - Typically Preferred Brand</b>  <i>Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).</i>  <i>Per 90 day supply (home delivery).</i></p>	<p>No charge</p> <p>No charge</p>	<p>Not covered (retail and home delivery)</p> <p>Not covered (retail and home delivery)</p>
<p><b>Tier 1 - Typically Generic</b>  <i>Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).</i>  <i>Per 90 day supply (home delivery).</i></p>	<p>\$10 copay per prescription after deductible is met (retail and home delivery)</p>	<p>Not covered (retail and home delivery)</p>
<p><b>Tier 2 – Typically Preferred Brand</b>  <i>Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).</i>  <i>Per 90 day supply (home delivery).</i></p>	<p>\$35 copay per prescription after deductible is met (retail) and \$70 copay per prescription after deductible is met (home delivery)</p>	<p>Not covered (retail and home delivery)</p>
<p><b>Tier 3 - Typically Non-Preferred Brand</b>  <i>Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).</i>  <i>Per 90 day supply (home delivery).</i></p>	<p>\$55 copay per prescription after deductible is met (retail) and \$165 copay per prescription after</p>	<p>Not covered (retail and home delivery)</p>

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
	deductible is met (home delivery)	
<b>Tier 4 - Typically Specialty (brand and generic)</b> <i>Per 30 day supply (specialty pharmacy).</i>	20% coinsurance up to \$200 per prescription after deductible is met (retail) and (home delivery)	Not covered (retail and home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<i>This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.</i>		
<b><u>Children's Vision (up to age 19)</u></b>		
<b>Child Vision Deductible</b>	\$0 person	\$0 person
<b>Vision exam</b> <i>Limited to 1 exam per benefit period.</i>	\$15 copay deductible does not apply	Reimbursed Up to \$30
<b><u>Adult Vision (age 19 and older)</u></b>		
<b>Adult Vision Deductible</b>	\$0 person	\$0 person
<b>Vision exam</b> <i>Limited to 1 exam per benefit period.</i>	\$15 copay deductible does not apply	Reimbursed Up to \$30

**Notes:**

- The representations of benefits in this document are subject to Division of Insurance approval and are subject to change.
- 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.
- All medical services subject to a coinsurance are also subject to the annual medical deductible, if deductible is applicable to plan.
- If your plan includes a hospital stay copay and you are readmitted within 72 hours of a prior admission for the same diagnosis, your hospital stay copay for your readmission is waived.
- If your plan includes out of network benefits and you use a non-participating provider, you are responsible for any difference between the covered expense and the actual non-participating providers charge.
- In-network preventive care is not subject to deductible, if you plan has a deductible.
- If your plan includes out of network benefits and you use a non-participating provider, you are responsible for any difference between the covered expense and the actual non-participating providers charge. When receiving care from providers out of network, members may be subject to balance billing in addition to any applicable copayments, coinsurance and/or deductible. This amount does not apply to the out of network out of pocket limit.
- For additional information on this plan, please visit [www.sbc.anthem.com](http://www.sbc.anthem.com) to obtain a “Summary of Benefits and Coverage”.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- Your copays, coinsurance and deductible count toward your out of pocket amount.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.

*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.*

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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) 597-2358

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) 597-2358.

**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) 597-2358:

**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) 597-2358。

**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) 597-2358 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) 597-2358.

**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) 597-2358.

**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) 597-2358.

**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) 597-2358 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) 597-2358로 문의하십시오.

## Language Access Services:

**Navajo (Diné):** Dii naaltsoos biká'ígíí lahgo bina'idiikidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj̄ bee nił hodoonił t'áadoo báąh ilinígóó. Ata' halne'ígíí la' bich'į' hadeesdzih ninizingo koj̄' hodíilnih (833) 597-2358.

**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) 597-2358.

**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 ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (833) 597-2358 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) 597-2358.

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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) 597-2358.

### 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>.

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VA/LG/Virginia Private Colleges: Plan 8 HMO HSA (Embedded Deductible)/480Z/01-01-2026

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  Specialist	0% coinsurance after deductible is met  0% coinsurance after deductible is met	30% coinsurance after deductible is met  30% coinsurance after deductible is met
<b>Video Visits with Live Health Online</b> via the Sydney mobile app or on Anthem.com  Primary Care (PCP) and Mental Health and Substance Abuse  Specialist Care	0% coinsurance after deductible is met  0% coinsurance after deductible is met	
<u><b>Visits in an Office</b></u>  <b>Primary Care (PCP)</b>  <b>Specialist Care</b>	0% coinsurance after deductible is met  0% coinsurance after deductible is met	30% coinsurance after deductible is met  30% coinsurance after deductible is met
<u><b>Other Practitioner Visits</b></u>  <b>Routine Maternity Care</b> (Prenatal and Postnatal)  <b>Retail Health Clinic</b>  <b>Manipulation Therapy</b> <i>Coverage is limited to 30 visits per benefit period.</i>	0% coinsurance after deductible is met  0% coinsurance after deductible is met  0% coinsurance after deductible is met	30% coinsurance after deductible is met  30% 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>Chemo/Radiation Therapy</b>  <b>Dialysis/Hemodialysis</b>	0% coinsurance after deductible is met  0% coinsurance after deductible is met  0% coinsurance after deductible is met	30% coinsurance after deductible is met  30% coinsurance after deductible is met  30% coinsurance after deductible is met
<b>Prescription Drugs</b> <i>Dispensed in the office</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Surgery</b>	0% 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
<p><b><u>Diagnostic Services</u></b>  <b>Lab</b></p> <p>Office</p> <p>Preferred Reference Lab</p> <p>Outpatient Hospital</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><b>X-Ray</b></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><b>Advanced Diagnostic Imaging</b> <i>for example: MRI, PET and CAT scans</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><b><u>Emergency and Urgent Care</u></b></p> <p><b>Urgent Care</b></p> <p><b>Emergency Room Facility Services</b></p> <p><b>Emergency Room Doctor and Other Services</b></p> <p><b>Ambulance</b></p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><b><u>Outpatient Mental Health and Substance Abuse</u></b></p> <p><b>Doctor Office Visit</b></p>	<p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p><b>Facility Visit</b></p> <p>Facility Fees</p>	<p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Doctor Services	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<p><b><u>Outpatient Surgery</u></b></p> <p><b>Facility Fees</b></p> <p>Hospital</p> <p>Freestanding Surgical Center</p> <p><b>Doctor and Other Services</b></p> <p>Hospital</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><b><u>Hospital (Including Maternity, Mental Health and Substance Abuse)</u></b></p> <p><b>Facility Fees</b></p> <p><b>Doctor and other services</b></p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><b><u>Recovery &amp; Rehabilitation</u></b></p> <p><b>Home Health Care</b>  <i>Coverage is limited to 90 visits per benefit period. Limits are combined for all home health services.</i></p>	<p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p><b>Rehabilitation services</b>  <i>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.</i></p> <p>Office</p>	<p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p>Outpatient Hospital</p>	<p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>Cardiac rehabilitation</b>  <i>Coverage for cardiac rehabilitation is unlimited visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings</i></p> <p>Office</p>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<p>Outpatient Hospital</p>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<p><b>Skilled Nursing Care (facility)</b>  <i>Coverage is limited to 100 days per admission. Limit is combined In-Network and Non-Network.</i></p>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<p><b>Hospice</b></p>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<p><b>Durable Medical Equipment</b></p>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<p><b>Prosthetic Devices</b>  <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period. Limit is combined In-Network and Non-Network.</i></p>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<p><b>Hearing Aids</b>  <i>One hearing aid per hearing impaired ear per 36 months, for adults and children, includes wearable and bone anchored hearing aids. \$2,500 benefit maximum.</i></p>	0% coinsurance after deductible is met	40% coinsurance after deductible is met
<p><b>Autism Spectrum Disorder (ASD)</b>            Therapeutic Care: unlimited physical, occupational and speech Therapy</p> <p>Applied Behavioral Analysis</p>	<p><b>0%</b> of the amount the health care professionals in our network have agreed to accept for their services</p> <p><b>0%</b> of the amount the health care professionals in our network have agreed to accept for their services</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<b>Pharmacy Deductible</b>	Combined with In-Network medical deductible	Combined with out of Network medical deductible
<b>Pharmacy Out-of-Pocket Limit</b>	Combined with In-Network medical out-of-pocket limit	Not covered
<p><b>Prescription Drug Coverage</b> Cost shares for drugs included on the Essential Direct drug list appear below. Your plan uses the Advantage Network. You may receive up to a 90 day supply of medication at Rx Maintenance 90 pharmacies. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply. Drug cost share assistance programs may be available for certain specialty drugs.</p>		
<p><b>Home Delivery Pharmacy</b> 90 day supply (maximum cost shares noted below). Maintenance medications are available through CarelonRx Mail or at a participating Rx Maintenance 90 pharmacies. You may get two 30 day supply fills of the same maintenance medication at a retail pharmacy. Prior to your 3rd fill, you must switch to home delivery.</p>		
<p><b>Preventive Drugs</b> No deductible, copayment or coinsurance for In-Network drugs included on the VPCBC Preventive Rx drug list, a designated list of drugs for the treatment of diabetes, asthma, depression, heart health, high blood pressure, high cholesterol, and osteoporosis. The list is free of charge and is not subject to the deductible.</p>		
<p><b>Tier 1 Preventive - Typically Generic</b>  <i>Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).</i>  <i>Per 90 day supply (home delivery).</i></p> <p><b>Tier 2 Preventive - Typically Preferred Brand</b>  <i>Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).</i>  <i>Per 90 day supply (home delivery).</i></p>	<p>No charge</p> <p>No charge</p>	<p>Not covered (retail and home delivery)</p> <p>Not covered (retail and home delivery)</p>
<p><b>Tier 1 - Typically Generic</b>  <i>Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).</i>  <i>Per 90 day supply (home delivery).</i></p>	<p>\$10 copay per prescription after deductible is met (retail and home delivery)</p>	<p>Not covered (retail and home delivery)</p>
<p><b>Tier 2 – Typically Preferred Brand</b>  <i>Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).</i>  <i>Per 90 day supply (home delivery).</i></p>	<p>\$35 copay per prescription after deductible is met (retail) and \$70 copay per prescription after deductible is met (home delivery)</p>	<p>Not covered (retail and home delivery)</p>
<p><b>Tier 3 - Typically Non-Preferred Brand</b>  <i>Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).</i>  <i>Per 90 day supply (home delivery).</i></p>	<p>\$55 copay per prescription after deductible is met (retail) and \$165 copay per prescription after</p>	<p>Not covered (retail and home delivery)</p>

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
	deductible is met (home delivery)	
<b>Tier 4 - Typically Specialty (brand and generic)</b> <i>Per 30 day supply (specialty pharmacy).</i>	20% coinsurance up to \$200 per prescription after deductible is met (retail) and (home delivery)	Not covered (retail and home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<i>This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.</i>		
<b><u>Children's Vision (up to age 19)</u></b>		
<b>Child Vision Deductible</b>	\$0 person	\$0 person
<b>Vision exam</b> <i>Limited to 1 exam per benefit period.</i>	\$15 copay deductible does not apply	Reimbursed Up to \$30
<b><u>Adult Vision (age 19 and older)</u></b>		
<b>Adult Vision Deductible</b>	\$0 person	\$0 person
<b>Vision exam</b> <i>Limited to 1 exam per benefit period.</i>	\$15 copay deductible does not apply	Reimbursed Up to \$30

**Notes:**

- The representations of benefits in this document are subject to Division of Insurance approval and are subject to change.
- 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.
- All medical services subject to a coinsurance are also subject to the annual medical deductible, if deductible is applicable to plan.
- If your plan includes a hospital stay copay and you are readmitted within 72 hours of a prior admission for the same diagnosis, your hospital stay copay for your readmission is waived.
- If your plan includes out of network benefits and you use a non-participating provider, you are responsible for any difference between the covered expense and the actual non-participating providers charge.
- In-network preventive care is not subject to deductible, if you plan has a deductible.
- If your plan includes out of network benefits and you use a non-participating provider, you are responsible for any difference between the covered expense and the actual non-participating providers charge. When receiving care from providers out of network, members may be subject to balance billing in addition to any applicable copayments, coinsurance and/or deductible. This amount does not apply to the out of network out of pocket limit.
- For additional information on this plan, please visit [www.sbc.anthem.com](http://www.sbc.anthem.com) to obtain a “Summary of Benefits and Coverage”.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- Your copays, coinsurance and deductible count toward your out of pocket amount.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.

*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.*

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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) 597-2358

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) 597-2358.

**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) 597-2358:

**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) 597-2358。

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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) 597-2358.

**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) 597-2358.

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**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) 597-2358 にお電話ください。

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## Language Access Services:

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# Your summary of benefits



**Anthem** HealthKeepers

Anthem® HealthKeepers Inc.

Your Plan: Virginia Private Colleges: Plan 9 HMO-POS Open Access

Your Network: HealthKeepers

This Schedule provides just a summary of the Covered Expenses, Limitations and Exclusions under the Plan. All benefits below are subject to the Plan's terms and conditions, including Deductibles, Coinsurance, In Network discounts and Allowable Charges, as set forth in the Plan Document to which this Schedule is attached. Please read this Schedule only in conjunction with the Plan Document.

Benefits payable by the Plan may change depending upon whether Covered Services are obtained from a Participating Provider. The list of Participating Providers may change from time to time. A list of Participating Providers is located at <http://www.anthem.com>. Therefore, it is important to verify that the Provider who is treating you is currently a Participating Provider.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b>	\$0 person / \$0 family	\$1,000 person / \$2,000 family
<b>Out-of-Pocket Limit</b>	\$2,500 person / \$5,000 family	\$3,500 person / \$7,000 family
<p>When more than a single person is enrolled, the per person deductible does not apply and the family deductible must be met by any one person or collection of persons, but each is capped at his or her per person out-of-pocket maximum for covered services applied to the family deductible.</p> <p>Your copays, coinsurance and deductible count toward your out of pocket amount(s).</p> <p>In-network and out-of-network out-of-pocket maximum amounts are separate and do not accumulate toward each other.</p>		
<b>Preventive Care / Screening / Immunization</b>	No charge	30% coinsurance after medical deductible is met
<b>Preventive Care for Chronic Conditions</b> <i>per IRS guidelines</i>	No charge	30% coinsurance after medical deductible is met
<b><u>Virtual Care (Telemedicine / Telehealth Visits)</u></b>		
<b>Virtual Visits - Online visits with Doctors who also provide services in person</b>		
Primary Care (PCP)	\$25 copay per visit	30% coinsurance after medical deductible is met

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Questions: (833) 597-2358 or visit us at [www.anthem.com](http://www.anthem.com)

VA/LG/Virginia Private Colleges: Plan 9 HMO-POS Open Access/480T/01-01-2026

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Mental Health and Substance Abuse care</p> <p>Specialist</p>	\$25 copay per visit	30% coinsurance after medical deductible is met
	\$50 copay per visit	30% coinsurance after medical deductible is met
<p><b>Video Visits with Live Health Online</b> via the Sydney mobile app or on Anthem.com</p> <p>Primary Care (PCP) and Mental Health and Substance Abuse</p> <p>Specialist Care</p>	<p>\$5 copay per visit</p> <p>\$50 copay per visit</p>	
<p><b><u>Visits in an Office</u></b></p> <p><b>Primary Care (PCP)</b></p> <p><b>Specialist Care</b></p>	\$25 copay per visit	30% coinsurance after medical deductible is met
	\$50 copay per visit	30% coinsurance after medical deductible is met
<p><b><u>Other Practitioner Visits</u></b></p> <p><b>Routine Maternity Care</b> (Prenatal and Postnatal) <i>Copay only applies to initial visit.</i></p> <p><b>Retail Health Clinic</b></p> <p><b>Manipulation Therapy</b> <i>Coverage is limited to 30 visits per benefit period.</i></p>	<p>\$25 PCP/\$50 Spec. copay per pregnancy for the first 1 visit \$300 per pregnancy</p> <p>\$25 copay per visit</p> <p>\$25 copay per visit</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b><u>Other Services in an Office</u></b></p> <p><b>Allergy Testing</b></p> <p><b>Chemo/Radiation Therapy</b></p> <p><b>Dialysis/Hemodialysis</b></p> <p><b>Prescription Drugs</b> <i>Dispensed in the office</i></p> <p><b>Surgery</b></p>	<p>\$25 PCP/\$50 Spec. copay per visit<sup>†</sup></p> <p>\$25 PCP/\$50 Spec. copay per visit<sup>†</sup></p> <p>\$50 copay per visit</p> <p>No charge</p> <p>\$25 PCP/\$50 Spec. copay per visit<sup>†</sup></p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>
<p><b><u>Diagnostic Services</u></b></p> <p><b>Lab</b></p> <p>Office</p> <p>Preferred Reference Lab</p> <p>Outpatient Hospital</p>	<p>\$25 PCP/\$50 Spec. copay per visit</p> <p>No charge</p> <p>No charge</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>
<p><b>X-Ray</b></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$25 PCP/\$50 Spec. copay per visit</p> <p>\$50 copay per visit</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>Advanced Diagnostic Imaging</b> <i>for example: MRI, PET and CAT scans</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$300 copay per visit</p> <p>\$300 copay per visit</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>
<p><b><u>Emergency and Urgent Care</u></b></p> <p><b>Urgent Care</b></p> <p><b>Emergency Room Facility Services</b> <i>Copay waived if admitted.</i></p> <p><b>Emergency Room Doctor and Other Services</b></p> <p><b>Ambulance</b></p>	<p>\$25 PCP/\$50 Spec. copay per visit</p> <p>\$250 copay per visit</p> <p>No charge</p> <p>\$100 copay per trip</p>	<p>30% coinsurance after medical deductible is met</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p><b><u>Outpatient Mental Health and Substance Abuse</u></b></p> <p><b>Doctor Office Visit</b></p> <p><b>Facility Visit</b></p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>\$25 copay per visit</p> <p>\$25 copay per visit</p> <p>No charge</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>
<p><b><u>Outpatient Surgery</u></b></p> <p><b>Facility Fees</b></p> <p>Hospital</p> <p>Freestanding Surgical Center</p>	<p>\$300 copay per visit</p> <p>\$300 copay per visit</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Doctor and Other Services</b> Hospital	No charge	30% coinsurance after medical deductible is met
<u><b>Hospital (Including Maternity, Mental Health and Substance Abuse)</b></u>  <b>Facility Fees</b>  <b>Doctor and other services</b>	\$350 copay per day to a maximum of \$1,750 per admission  No charge	30% coinsurance after medical deductible is met  30% coinsurance after medical deductible is met
<u><b>Recovery &amp; Rehabilitation</b></u>  <b>Home Health Care</b> <i>Coverage is limited to 90 visits per benefit period. Limits are combined for all home health services.</i>	No charge	30% coinsurance after medical deductible is met
<b>Rehabilitation services</b> <i>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. Limit is combined In-Network and Non-Network.</i>  Office  Outpatient Hospital	\$25 copay per visit  \$25 copay per visit	30% coinsurance after medical deductible is met  30% coinsurance after medical deductible is met
<b>Cardiac rehabilitation</b> Limit is combined In-Network and Non-Network across all outpatient settings.  Office  Outpatient Hospital	\$25 PCP/ \$50 Spec. copay per visit  \$50 copay per visit	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
<p><b>Skilled Nursing Care (facility)</b>  <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 100 days combined per admission. Limit is combined In-Network and Non-Network.</i></p>	No charge	30% coinsurance after medical deductible is met
<p><b>Hospice</b></p>	No charge	30% coinsurance after medical deductible is met
<p><b>Durable Medical Equipment</b></p>	No charge	30% coinsurance after medical deductible is met
<p><b>Prosthetic Devices</b>  <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period. Limit is combined In-Network and Non-Network.</i></p>	No charge	30% coinsurance after medical deductible is met
<p><b>Hearing Aids</b>  <i>One hearing aid per hearing impaired ear per 36 months, for adults and children, includes wearable and bone anchored hearing aids. \$2,500 benefit maximum.</i></p>	No charge	30% coinsurance after medical deductible is met
<p><b>Autism Spectrum Disorder (ASD)</b></p> <p>Therapeutic Care: unlimited physical, occupational and speech Therapy.</p> <p>Applied Behavioral Analysis</p>	<p><b>Office Visit: \$25</b> for each visit  <b>Outpatient Facility: \$25</b> for each visit</p> <p><b>20%</b> of the amount the health care professionals in our network have agreed to accept for their services</p>	<p><b>30%</b> coinsurance after medical deductible is met</p> <p><b>30%</b> coinsurance after medical deductible is met</p>

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<b>Pharmacy Deductible</b>	\$150 person / \$300 family	Not covered
<b>Pharmacy Out-of-Pocket Limit</b>	\$4,100 person / \$8,200 family	Not covered
<p><b>Prescription Drug Coverage</b> Cost shares for drugs included on the Essential Direct drug list appear below. Your plan uses the Advantage Network. You may receive up to a 90 day supply of medication at Rx Maintenance 90 pharmacies. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply. Drug cost share assistance programs may be available for certain specialty drugs.</p>		
<p><b>Home Delivery Pharmacy</b> 90 day supply (maximum cost shares noted below). Maintenance medications are available through CarelonRx Mail or at a participating Rx Maintenance 90 pharmacies. You may get two 30 day supply fills of the same maintenance medication at a retail pharmacy. Prior to your 3rd fill, you must switch to home delivery.</p>		
<p><b>Preventive Drugs</b> No deductible, copayment or coinsurance for In-Network drugs included on the VPCBC Preventive Rx drug list, a designated list of drugs for the treatment of diabetes, asthma, depression, heart health, high blood pressure, high cholesterol, and osteoporosis. This list is free of charge and are not subject to the deductible.</p>		
<p><b>Tier 1 Preventive - Typically Generic</b> Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy). Per 90 day supply (home delivery).</p>	No charge	Not covered (retail and home delivery)
<p><b>Tier 2 Preventive - Typically Preferred Brand</b> Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy). Per 90 day supply (home delivery).</p>	No charge	Not covered (retail and home delivery)
<p><b>Tier 1 - Typically Generic</b> Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy). Per 90 day supply (home delivery).</p>	\$10 copay per prescription Pharmacy deductible does not apply (retail and home delivery)	Not covered (retail and home delivery)
<p><b>Tier 2 – Typically Preferred Brand</b> Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy). Per 90 day supply (home delivery).</p>	Greater of \$40 or 30% coinsurance up to \$80 per prescription after Pharmacy deductible is met (retail) and Greater of \$80 or 30% coinsurance up to \$160 per prescription after Pharmacy deductible is met (home delivery)	Not covered (retail and home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<b>Tier 3 - Typically Non-Preferred Brand</b> <i>Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).</i> <i>Per 90 day supply (home delivery).</i>	Greater of \$60 or 40% coinsurance up to \$120 per prescription after Pharmacy deductible is met (retail) and Greater of \$120 or 40% coinsurance up to \$240 per prescription after Pharmacy deductible is met (home delivery)	Not covered (retail and home delivery)
<b>Tier 4 - Typically Specialty (brand and generic)</b> <i>Per 30 day supply (specialty pharmacy).</i>	50% coinsurance up to \$200 per prescription after Pharmacy deductible is met (retail) and (home delivery)	Not covered (retail and home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<i>This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.</i>		
<b><u>Children's Vision (up to age 19)</u></b>		
<b>Child Vision Deductible</b>	\$0 person	\$0 person
<b>Vision exam</b> <i>Limited to 1 exam per benefit period.</i>	\$15 copay	Reimbursed Up to \$30
<b><u>Adult Vision (age 19 and older)</u></b>		
<b>Adult Vision Deductible</b>	\$0 person	\$0 person
<b>Vision exam</b> <i>Limited to 1 exam per benefit period.</i>	\$15 copay	Reimbursed Up to \$30

**Notes:**

- The representations of benefits in this document are subject to Division of Insurance approval and are subject to change.
- 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.
- ‡ Your cost share will be reduced when services are provided in a PCP's office.
- All medical services subject to a coinsurance are also subject to the annual medical deductible, if deductible is applicable to plan.
- If your plan includes a hospital stay copay and you are readmitted within 72 hours of a prior admission for the same diagnosis, your hospital stay copay for your readmission is waived.  
If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- If your plan includes out of network benefits and you use a non-participating provider, you are responsible for any difference between the covered expense and the actual non-participating provider's charge.
- In-network preventive care is not subject to deductible, if your plan has a deductible.
- If your plan includes out of network benefits and you use a non-participating provider, you are responsible for any difference between the covered expense and the actual non-participating provider's charge. When receiving care from providers out of network, members may be subject to balance billing in addition to any applicable copayments, coinsurance and/or deductible. This amount does not apply to the out of network out of pocket limit.
- For additional information on this plan, please visit [www.sbc.anthem.com](http://www.sbc.anthem.com) to obtain a “Summary of Benefits and Coverage”.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- Your copays, coinsurance and deductible count toward your out of pocket amount.
- Out of pocket prescription drug cost do not count towards the Medical out of pocket maximum.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.
- Any amount you pay toward your medical deductible during the 4<sup>th</sup> quarter of each calendar year (Oct-Dec) will apply not only to your deductible for that year but will also apply to your deductible for the following year.

*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.*

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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) 597-2358

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) 597-2358.

**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) 597-2358:

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**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) 597-2358.

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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>.

# Your summary of benefits



**Anthem**. HealthKeepers

Anthem® HealthKeepers Inc.

Your Plan: Virginia Private Colleges: Plan 10 HMO-POS Open Access

Your Network: HealthKeepers

This Schedule provides just a summary of the Covered Expenses, Limitations and Exclusions under the Plan. All benefits below are subject to the Plan's terms and conditions, including Deductibles, Coinsurance, In Network discounts and Allowable Charges, as set forth in the Plan Document to which this Schedule is attached. Please read this Schedule only in conjunction with the Plan Document.

Benefits payable by the Plan may change depending upon whether Covered Services are obtained from a Participating Provider. The list of Participating Providers may change from time to time. A list of Participating Providers is located at <http://www.anthem.com>. Therefore, it is important to verify that the Provider who is treating you is currently a Participating Provider.

Deductible does not apply to copay services or preventive care.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b>	\$300 person / \$600 family	\$1,000 person / \$2,000 family
<b>Out-of-Pocket Limit</b>	\$2,000 person / \$4,000 family	\$3,500 person / \$7,000 family
<p>When more than a single person is enrolled, the per person deductible does not apply and the family deductible must be met by any one person or collection of persons, but each is capped at his or her per person out-of-pocket maximum for covered services applied to the family deductible.</p> <p>Your copays, coinsurance and deductible count toward your out of pocket amount(s).</p> <p>In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other.</p>		
<b>Preventive Care / Screening / Immunization</b>	No charge	30% coinsurance after medical deductible is met
<b>Preventive Care for Chronic Conditions</b> <i>per IRS guidelines</i>	No charge	30% coinsurance after medical deductible is met

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VA/LG/Virginia Private Colleges: Plan 10 HMO-POS Open Access/4810/01-01-2026

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b><u>Virtual Care (Telemedicine / Telehealth Visits)</u></b></p> <p><b>Virtual Visits - Online visits with Doctors who also provide services in person</b></p> <p>Primary Care (PCP)</p> <p>Mental Health and Substance Abuse care</p> <p>Specialist</p>	<p>\$20 copay per visit medical deductible does not apply</p> <p>\$20 copay per visit medical deductible does not apply</p> <p>\$40 copay per visit medical deductible does not apply</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>
<p><b>Video Visits with Live Health Online</b> via the Sydney mobile app or on Anthem.com</p> <p>Primary Care (PCP) and Mental Health and Substance Abuse</p> <p>Specialist Care</p>	<p>\$5 copay per visit medical deductible does not apply</p> <p>\$40 copay per visit medical deductible does not apply</p>	
<p><b><u>Visits in an Office</u></b></p> <p><b>Primary Care (PCP)</b></p> <p><b>Specialist Care</b></p>	<p>\$20 copay per visit medical deductible does not apply</p> <p>\$40 copay per visit medical deductible does not apply</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>
<p><b><u>Other Practitioner Visits</u></b></p> <p><b>Routine Maternity Care</b> (Prenatal and Postnatal)  <i>All office visit copayments count towards the same 1 visit limit. Copay for initial visit only. Limit is combined In-Network and Non- Network.</i></p> <p><b>Retail Health Clinic</b></p>	<p>\$20 PCP/\$40 Spec. copay per pregnancy for the first 1 visit . \$200 per pregnancy</p> <p>\$20 copay per visit medical deductible does not apply</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>
<p><b>Manipulation Therapy</b>  <i>Coverage is limited to 30 visits per benefit period.</i></p>	<p>\$25 copay per visit medical deductible does not apply</p>	<p>30% coinsurance after medical deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b><u>Other Services in an Office</u></b></p> <p><b>Allergy Testing</b></p> <p><b>Chemo/Radiation Therapy</b></p> <p><b>Dialysis/Hemodialysis</b></p> <p><b>Prescription Drugs</b> <i>Dispensed in the office</i></p> <p><b>Surgery</b></p>	<p>\$20 PCP/\$40 Spec. copay per visit medical deductible does not apply<sup>†</sup></p> <p>\$40 copay per visit medical deductible does not apply<sup>†</sup></p> <p>\$40 copay per month medical deductible does not apply<sup>†</sup></p> <p>No charge</p> <p>20 PCP/\$40 Spec. copay per visit medical deductible does not apply<sup>†</sup></p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>
<p><b><u>Diagnostic Services</u></b></p> <p><b>Lab</b></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$20 PCP/\$40 Spec. copay per visit medical deductible does not apply</p> <p>20% coinsurance after medical deductible is met</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>
<p><b>X-Ray</b></p> <p>Office</p>	<p>\$20/ \$40 Spec. copay per visit medical deductible does not apply</p>	<p>30% coinsurance after medical deductible is met</p>
<p>Outpatient Hospital</p>	<p>20% coinsurance after medical deductible is met</p>	<p>30% coinsurance after medical deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>Advanced Diagnostic Imaging</b> <i>for example: MRI, PET and CAT scans</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>
<p><b><u>Emergency and Urgent Care</u></b></p> <p><b>Urgent Care</b></p> <p><b>Emergency Room Facility Services</b></p> <p><b>Emergency Room Doctor and Other Services</b></p> <p><b>Ambulance</b></p>	<p>\$20 PCP/\$40 Spec. copay per visit medical deductible does not apply</p> <p>20% coinsurance after medical deductible is met</p> <p>No charge</p> <p>\$100 copay per trip medical deductible does not apply</p>	<p>30% coinsurance after medical deductible is met</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p><b><u>Outpatient Mental Health and Substance Abuse</u></b></p> <p><b>Doctor Office Visit</b></p> <p><b>Facility Visit</b></p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>\$20 copay per visit medical deductible does not apply</p> <p>No charge</p> <p>20% coinsurance after medical deductible is met</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b><u>Outpatient Surgery</u></b></p> <p><b>Facility Fees</b></p> <p>Hospital</p> <p>Freestanding Surgical Center</p> <p><b>Doctor and Other Services</b></p> <p>Hospital</p>	<p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>
<p><b><u>Hospital (Including Maternity, Mental Health and Substance Abuse)</u></b></p> <p><i>Limit is combined In-Network and Non-Network.</i></p> <p><b>Facility Fees</b></p> <p><b>Doctor and other services</b></p>	<p>20% coinsurance after medical deductible is met</p> <p>No charge</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>
<p><b><u>Recovery &amp; Rehabilitation</u></b></p> <p><b>Home Health Care</b></p> <p><i>Coverage is limited to 90 visits per benefit period. Limits are combined for all home health services</i></p>	<p>20% coinsurance after medical deductible is met</p>	<p>30% coinsurance after medical deductible is met</p>
<p><b>Rehabilitation services</b></p> <p><i>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. Limit is combined In-Network and Non-Network.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$25 copay per visit medical deductible does not apply</p> <p>20% coinsurance after medical deductible is met</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>Cardiac rehabilitation</b> Limit is combined In-Network and Non-Network.</p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$20 PCP/\$40 Spec. copay per visit medical deductible does not apply</p> <p>20% coinsurance after medical deductible is met</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>
<p><b>Skilled Nursing Care (facility)</b> <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 100 days combined per admission. Limit is combined In-Network and Non-Network.</i></p>	<p>20% coinsurance after medical deductible is met</p>	<p>30% coinsurance after medical deductible is met</p>
<p><b>Hospice</b></p>	<p>No charge</p>	<p>30% coinsurance after medical deductible is met</p>
<p><b>Durable Medical Equipment</b></p>	<p>20% coinsurance after medical deductible is met</p>	<p>30% coinsurance after medical deductible is met</p>
<p><b>Prosthetic Devices</b> <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period. Limit is combined In-Network and Non-network.</i></p>	<p>20% coinsurance after medical deductible is met</p>	<p>30% coinsurance after medical deductible is met</p>
<p><b>Hearing Aids</b> <i>One hearing aid per hearing impaired ear per 36 months, for adults and children, includes wearable and bone anchored hearing aids. \$2,500 benefit maximum.</i></p>	<p>20% coinsurance after medical deductible is met</p>	<p>30% coinsurance after medical deductible is met</p>
<p><b>Autism Spectrum Disorder (ASD)</b></p> <p>Therapeutic Care: unlimited physical, occupational and speech Therapy</p> <p>Applied Behavioral Analysis</p>	<p><b>Office Visit: \$20</b> for each visit to a specialist's office; <b>Outpatient Facility: 20%</b> for each visit to a hospital or facility (after deductible) <b>20%</b> of the amount the health care professionals in our network have agreed to accept for their services (after deductible)</p>	<p><b>30%</b> coinsurance after medical deductible is met</p> <p><b>30%</b> coinsurance after medical deductible is met</p>

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<b>Pharmacy Deductible</b>	Not applicable	Not covered
<b>Pharmacy Out-of-Pocket Limit</b>	\$4,600 person / \$9,200 family	Not covered
<p><b>Prescription Drug Coverage</b> Cost shares for drugs included on the Essential Direct drug list appear below. Your plan uses the Advantage Network. You may receive up to a 90 day supply of medication at Rx Maintenance 90 pharmacies. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply. Drug cost share assistance programs may be available for certain specialty drugs.</p>		
<p><b>Home Delivery Pharmacy</b> 90 day supply (maximum cost shares noted below). Maintenance medications are available through CarelonRx Mail or at a participating Rx Maintenance 90 pharmacies. You may get two 30 day supply fills of the same maintenance medication at a retail pharmacy. Prior to your 3rd fill, you must switch to home delivery.</p>		
<p><b>Preventive Drugs</b> No deductible, copayment or coinsurance for In-Network drugs included on the VPCBC Preventive RX drug list, a designated list of drugs for the treatment of diabetes, asthma, depression, heart health, high blood pressure, high cholesterol, and osteoporosis. This list is free of charge and is not subject to the deductible.</p>		
<p><b>Tier 1 Preventive - Typically Generic</b> Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy). Per 90 day supply (home delivery).</p>	No charge	Not covered (retail and home delivery)
<p><b>Tier 2 Preventive - Typically Preferred Brand</b> Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy). Per 90 day supply (home delivery).</p>	No charge	Not covered (retail and home delivery)
<p><b>Tier 1 - Typically Generic</b> Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy). Per 90 day supply (home delivery).</p>	\$10 copay per prescription, deductible does not apply (retail and home delivery)	Not covered (retail and home delivery)
<p><b>Tier 2 – Typically Preferred Brand</b> Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy). Per 90 day supply (home delivery).</p>	Greater of \$40 or 30% coinsurance up to \$80 per prescription, deductible does not apply (retail) and Greater of \$80 or 30% coinsurance up to \$160 per prescription, deductible does not apply (home delivery)	Not covered (retail and home delivery)
<b>Tier 3 - Typically Non-Preferred Brand</b>	Greater of \$60 or 40% coinsurance up to \$120	Not covered (retail and home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<p><i>Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).</i>  <i>Per 90 day supply (home delivery).</i></p>	<p>per prescription, deductible does not apply (retail) and Greater of \$120 or 40% coinsurance up to \$240 per prescription, deductible does not apply (home delivery)</p>	
<p><b>Tier 4 - Typically Specialty (brand and generic)</b>  <i>Per 30 day supply (specialty pharmacy).</i></p>	<p>50% coinsurance up to \$200 per prescription, deductible does not apply (retail) and (home delivery)</p>	<p>Not covered (retail and home delivery)</p>

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><i>This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.</i></p>		
<p><b><u>Children's Vision (up to age 19)</u></b></p>		
<p><b>Child Vision Deductible</b></p>	<p>\$0 person</p>	<p>\$0 person</p>
<p><b>Vision exam</b>  <i>Limited to 1 exam per benefit period.</i></p>	<p>\$15 copay deductible does not apply</p>	<p>Reimbursed Up to \$30</p>
<p><b><u>Adult Vision (age 19 and older)</u></b></p>		
<p><b>Adult Vision Deductible</b></p>	<p>\$0 person</p>	<p>\$0 person</p>
<p><b>Vision exam</b>  <i>Limited to 1 exam per benefit period.</i></p>	<p>\$15 copay deductible does not apply</p>	<p>Reimbursed Up to \$30</p>

**Notes:**

- The representations of benefits in this document are subject to Division of Insurance approval and are subject to change.
- 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.
- ‡ Your cost share will be reduced when services are provided in a PCP's office.
- All medical services subject to a coinsurance are also subject to the annual medical deductible, if deductible is applicable to plan.
- If your plan includes a hospital stay copay and you are readmitted within 72 hours of a prior admission for the same diagnosis, your hospital stay copay for your readmission is waived.
- If your plan includes out of network benefits and you use a non-participating provider, you are responsible for any difference between the covered expense and the actual non-participating provider's charge.
- In-network preventive care is not subject to deductible, if your plan has a deductible.
- If your plan includes out of network benefits and you use a non-participating provider, you are responsible for any difference between the covered expense and the actual non-participating provider's charge. When receiving care from providers out of network, members may be subject to balance billing in addition to any applicable copayments, coinsurance and/or deductible. This amount does not apply to the out of network out of pocket limit.
- For additional information on this plan, please visit [www.sbc.anthem.com](http://www.sbc.anthem.com) to obtain a “Summary of Benefits and Coverage”.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- Your copays, coinsurance and deductible count toward your out of pocket amount.
- Out of pocket prescription drug cost do not count towards the Medical out of pocket maximum.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.
- Any amount you pay toward your medical deductible during the 4<sup>th</sup> quarter of each calendar year (Oct-Dec) will apply not only to your deductible for that year but will also apply to your deductible for the following year.

*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.*

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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) 597-2358

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) 597-2358 .

**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) 597-2358 :

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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>.

# Your summary of benefits



**Anthem**. HealthKeepers

Anthem® HealthKeepers Inc.

Your Plan: Plan 11 HMO-POS Open Access

Your Network: HealthKeepers

This Schedule provides just a summary of the Covered Expenses, Limitations and Exclusions under the Plan. All benefits below are subject to the Plan's terms and conditions, including Deductibles, Coinsurance. In Network discounts and Allowable Charges, as set forth in the Plan Documents to which this Schedule is attached. Please read the schedule only in conjunction with the Plan Document.

Benefits payable by the Plan may change depending upon whether Covered Services are obtained from a Participating Provider. The list of Participating Providers may change from time to time. A list of Participating Providers is located at [www.anthem.com](http://www.anthem.com). Therefore, it is important to verify that the Provider who is treating you is currently a Participating Provider.

Deductible does not apply to copay services and preventive care services.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b>	\$750 person / \$1,500 family	\$1,000 person / \$2,000 family
<b>Out-of-Pocket Limit</b>	\$3,250 person / \$6,500 family	\$3,500 person / \$7,000 family
<p>When more than a single person is enrolled, the per person deductible does not apply and the family deductible must be met by any one person or collection of persons, but each is capped at his or her per person out-of-pocket maximum for covered services applied to the family deductible.</p> <p>Your copays, coinsurance and deductible count toward your out of pocket amount(s).</p> <p>In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other.</p>		
<b>Preventive Care / Screening / Immunization</b>	No charge	30% coinsurance after medical deductible is met
<b>Preventive Care for Chronic Conditions</b> <i>per IRS guidelines</i>	No charge	30% coinsurance after medical deductible is met

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VA/LG/Virginia Private Colleges: Plan 11 HMO-POS Open Access/4819/01-01-2026

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b><u>Virtual Care (Telemedicine / Telehealth Visits)</u></b></p> <p><b>Virtual Visits - Online visits with Doctors who also provide services in person</b></p> <p>Primary Care (PCP)</p> <p>Mental Health and Substance Abuse care</p> <p>Specialist</p>	<p>\$25 copay per visit medical deductible does not apply</p> <p>\$25 copay per visit medical deductible does not apply</p> <p>\$50 copay per visit medical deductible does not apply</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>
<p><b>Video Visits with Live Health Online</b> via the Sydney mobile app or on Anthem.com</p> <p>Primary Care (PCP) and Mental Health and Substance Abuse</p> <p>Specialist Care</p>	<p>\$5 copay per visit medical deductible does not apply</p> <p>\$50 copay per visit medical deductible does not apply</p>	
<p><b><u>Visits in an Office</u></b></p> <p><b>Primary Care (PCP)</b></p> <p><b>Specialist Care</b></p>	<p>\$25 copay per visit medical deductible does not apply</p> <p>\$50 copay per visit medical deductible does not apply</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>
<p><b><u>Other Practitioner Visits</u></b></p> <p><b>Routine Maternity Care</b> (Prenatal and Postnatal)  <i>All office visit copayments count towards the same 1 visit limit. Copay for initial visit only. Limit is combined In-Network and Non- Network.</i></p>	<p>\$25 PCP/\$50 Spec. copay per pregnancy for the first 1 visit .  \$200 per pregnancy</p>	<p>30% coinsurance after medical deductible is met</p>
<p><b>Retail Health Clinic</b></p>	<p>\$25 copay per visit medical deductible does not apply</p>	<p>30% coinsurance after medical deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Manipulation Therapy</b> <i>Coverage is limited to 30 visits per benefit period.</i>	\$25 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
<u><b>Other Services in an Office</b></u>  <b>Allergy Testing</b>   <b>Chemo/Radiation Therapy</b>   <b>Dialysis/Hemodialysis</b>   <b>Prescription Drugs</b> <i>Dispensed in the office</i>   <b>Surgery</b>	 \$25 PCP/\$50 Spec. copay per visit medical deductible does not apply <sup>†</sup>  \$25 PCP/\$50 Spec copay per visit medical deductible does not apply <sup>†</sup>  \$50 copay per visit medical deductible does not apply  20% coinsurance after medical deductible is met  \$25 PCP/\$50 Spec. copay per visit medical deductible does not apply <sup>†</sup>	 30% coinsurance after medical deductible is met  30% coinsurance after medical deductible is met  30% coinsurance after medical deductible is met  30% coinsurance after medical deductible is met  30% coinsurance after medical deductible is met
<u><b>Diagnostic Services</b></u> <b>Lab</b> Office  Preferred Reference Lab  Outpatient Hospital	 \$25 PCP/\$50 Spec copay per visit medical deductible does not apply  No charge  20% coinsurance after medical deductible is met	 30% coinsurance after medical deductible is met  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
<b>X-Ray</b>  Office  Outpatient Hospital	\$25 PCP/\$50 Spec copay per visit medical deductible does not apply  20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met  30% coinsurance after medical deductible is met
<b>Advanced Diagnostic Imaging</b> <i>for example: MRI, PET and CAT scans</i>  Office  Outpatient Hospital	20% coinsurance after medical deductible is met  20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met  30% coinsurance after medical deductible is met
<u><b>Emergency and Urgent Care</b></u>  <b>Urgent Care</b>  <b>Emergency Room Facility Services</b>  <b>Emergency Room Doctor and Other Services</b>  <b>Ambulance</b>	\$25 PCP/\$50 Spec copay per visit medical deductible does not apply  20% coinsurance after medical deductible is met  No charge  \$100 copay per trip medical deductible does not apply	30% coinsurance after medical deductible is met  Covered as In-Network  Covered as In-Network  Covered as In-Network
<u><b>Outpatient Mental Health and Substance Abuse</b></u>  <b>Doctor Office Visit</b>  <b>Facility Visit</b> Facility Fees	\$25 copay per visit medical deductible does not apply  No charge	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	No charge	30% coinsurance after medical deductible is met
<p><b><u>Outpatient Surgery</u></b></p> <p><b>Facility Fees</b></p> <p>Hospital</p> <p>Freestanding Surgical Center</p> <p><b>Doctor and Other Services</b></p> <p>Hospital</p>	<p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p> <p>No charge</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>
<p><b><u>Hospital (Including Maternity, Mental Health and Substance Abuse)</u></b></p> <p><b>Facility Fees</b></p> <p><b>Doctor and other services</b></p>	<p>20% coinsurance after medical deductible is met</p> <p>No charge</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>
<p><b><u>Recovery &amp; Rehabilitation</u></b></p> <p><b>Home Health Care</b></p>	No charge	30% coinsurance after medical deductible is met
<p><b>Rehabilitation services</b></p> <p><i>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. Limit is combined In-Network and Non-Network.</i></p> <p>Office</p>	\$25 copay per visit medical deductible does not apply	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
Outpatient Hospital	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
<p><b>Cardiac rehabilitation</b> Limit combined In-Network and Non-Network.</p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$25 PCP/\$50 Spec copay per visit medical deductible does not apply</p> <p>20% coinsurance after medical deductible is met</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>
<p><b>Skilled Nursing Care (facility)</b> <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 100 days combined per admission. Limit combined In-Network and Non-Network.</i></p>	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
<b>Hospice</b>	No charge	30% coinsurance after medical deductible is met
<b>Durable Medical Equipment</b>	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
<p><b>Prosthetic Devices</b> <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period. Limit is combined In-Network and Non- Network.</i></p>	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
<p><b>Hearing Aids</b> <i>One hearing aid per hearing impaired ear per 36 months, for adults and children, includes wearable and bone anchored hearing aids. \$2,500 benefit maximum.</i></p>	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
<p><b>Autism Spectrum Disorder (ASD)</b> Therapeutic Care: unlimited physical, occupational and speech therapy</p>	<p>Office Visit: \$25 for each visit to a specialist (deductible does not apply); Outpatient Facility: 20% for each stay at a hospital or facility (after meeting deductible)</p>	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
Applied Behavioral Analysis	20% of the amount the health care professionals in our network have agreed to accept for their services (after meeting deductible)	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
<b>Pharmacy Deductible</b>	\$150 person / \$300 family	Not covered
<b>Pharmacy Out-of-Pocket Limit</b>	\$3,350 person / \$6,700 family	Not covered
<p><b>Prescription Drug Coverage</b> Cost shares for drugs included on the Essential Direct drug list appear below. Your plan uses the Advantage Network. You may receive up to a 90 day supply of medication at Rx Maintenance 90 pharmacies. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply. Drug cost share assistance programs may be available for certain specialty drugs.</p>		
<p><b>Home Delivery Pharmacy.</b> 90 day supply (maximum cost shares noted below). Maintenance medications are available through CarelonRx Mail or at a participating Rx Maintenance 90 pharmacies.</p>		
<p><b>Preventive Drugs</b> Your Pharmacy cost share is waived for drugs included on the VPCBC Preventive Rx drug list, a designated list of drugs for the treatment of diabetes, asthma, depression, heart health, high blood pressure, high cholesterol, and osteoporosis. This list is free of charge and is not subject to the deductible.</p>		
<p><b>Tier 1 Preventive - Typically Generic</b>  <i>Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).</i>  <i>Per 90 day supply (home delivery).</i></p> <p><b>Tier 2 Preventive - Typically Preferred Brand</b>  <i>Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).</i>  <i>Per 90 day supply (home delivery).</i></p>	<p>No charge</p> <p>No charge</p>	<p>Not covered (retail and home delivery)</p> <p>Not covered (retail and home delivery)</p>

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<p><b>Tier 1 - Typically Generic</b>  <i>Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).</i>  <i>Per 90 day supply (home delivery).</i></p>	<p>\$10 copay per prescription the Pharmacy deductible does not apply (retail and home delivery)</p>	<p>Not covered (retail and home delivery)</p>
<p><b>Tier 2 – Typically Preferred Brand</b>  <i>Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).</i>  <i>Per 90 day supply (home delivery).</i></p>	<p>Greater of \$40 or 30% coinsurance up to \$80 per prescription after Pharmacy deductible is met (retail) and Greater of \$80 or 30% coinsurance up to \$160 per prescription after Pharmacy deductible is met (home delivery)</p>	<p>Not covered (retail and home delivery)</p>
<p><b>Tier 3 - Typically Non-Preferred Brand</b>  <i>Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).</i>  <i>Per 90 day supply (home delivery).</i></p>	<p>Greater of \$60 or 40% coinsurance up to \$120 per prescription after Pharmacy deductible is met (retail) and Greater of \$120 or 40% coinsurance up to \$240 per prescription after Pharmacy deductible is met (home delivery)</p>	<p>Not covered (retail and home delivery)</p>
<p><b>Tier 4 - Typically Specialty (brand and generic)</b>  <i>Per 30 day supply (specialty pharmacy).</i></p>	<p>50% coinsurance up to \$200 per prescription after Pharmacy deductible is met (retail) and (home delivery)</p>	<p>Not covered (retail and home delivery)</p>

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<i>This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.</i>		
<b><u>Children's Vision (up to age 19)</u></b> <b>Child Vision Deductible</b>	\$0 person	\$0 person
<b>Vision exam</b> <i>Limited to 1 exam per benefit period.</i>	\$15 copay deductible does not apply	Reimbursed Up to \$30
<b><u>Adult Vision (age 19 and older)</u></b> <b>Adult Vision Deductible</b>	\$0 person	\$0 person
<b>Vision exam</b> <i>Limited to 1 exam per benefit period.</i>	\$15 copay deductible does not apply	Reimbursed Up to \$30

**Notes:**

- The representations of benefits in this document are subject to Division of Insurance approval and are subject to change.
- 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.
- ‡ Your cost share will be reduced when services are provided in a PCP's office.
- All medical services subject to a coinsurance are also subject to the annual medical deductible, if deductible is applicable to plan.
- If your plan includes a hospital stay copay and you are readmitted within 72 hours of a prior admission for the same diagnosis, your hospital stay copay for your readmission is waived.
- If your plan includes out of network benefits and you use a non-participating provider, you are responsible for any difference between the covered expense and the actual non-participating provider's charge.
- In-network preventive care is not subject to deductible, if your plan has a deductible.
- If your plan includes out of network benefits and you use a non-participating provider, you are responsible for any difference between the covered expense and the actual non-participating provider's charge. When receiving care from providers out of network, members may be subject to balance billing in addition to any applicable copayments, coinsurance and/or deductible. This amount does not apply to the out of network out of pocket limit.
- For additional information on this plan, please visit [www.sbc.anthem.com](http://www.sbc.anthem.com) to obtain a “Summary of Benefits and Coverage”.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- Your copays, coinsurance and deductible count toward your out of pocket amount.
- Any amount you pay toward your medical deductible during the 4<sup>th</sup> quarter of each calendar year (Oct-Dec) will apply not only to your deductible for that year but will also apply to your deductible for the following year.
- Out of pocket prescription drug cost do not count towards the Medical out of pocket maximum.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.

*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.*

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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) 597-2358

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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