Your summary of benefits

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 dicounts and Allowable Charges, as set forth in the Plan Document to which this Schedule is attached. Please reat 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
Overall Deductible	$0 person / $0 family	$1,000 person / $2,000 family
Out-of-Pocket Limit	$2,500 person / $5,000 family	$3,500 person / $7,000 family
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. Your copays, coinsurance and deductible count toward your out of pocket amount(s). In-network and out-of-network out-of-pocket maximum amounts are separate and do not accumulate toward each other.		
Preventive Care / Screening / Immunization	No charge	30% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	30% coinsurance after medical deductible is met
Virtual Care (Telemedicine / Telehealth Visits) **Virtual Visits - Online visits with Doctors who also provide services in person**		
Primary Care (PCP)	$25 copay per visit	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
Mental Health and Substance Abuse care	$25 copay per visit	30% coinsurance after medical deductible is met
Specialist	$50 copay per visit	30% coinsurance after medical deductible is met
Medical Text Chats and Virtual Visits for Primary Care with K Health on the Sydney mobile app or on your Anthem.com account you will be transferred to the K Health app.	No charge	
Video Visits with Live Health Online via the Sydney mobile app or on Anthem.com		
Primary Care (PCP) and Mental Health and Substance Abuse	$5 copay per visit	
Specialist Care	$50 copay per visit	
Visits in an Office		
Primary Care (PCP)	$25 copay per visit	30% coinsurance after medical deductible is met
Specialist Care	$50 copay per visit	30% coinsurance after medical deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal) *Copay only applies to initial visit.*	$25 PCP/$50 Spec. copay per pregnancy for the first 1 visit $300 per pregnancy	30% coinsurance after medical deductible is met
Retail Health Clinic	$25 copay per visit	30% coinsurance after medical deductible is met
Manipulation Therapy *Coverage is limited to 30 visits per benefit period.*	$25 copay per visit	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
Other Services in an Office		
Allergy Testing	$25 PCP/$50 Spec. copay per visit‡	30% coinsurance after medical deductible is met
Chemo/Radiation Therapy	$25 PCP/$50 Spec. copay per visit‡	30% coinsurance after medical deductible is met
Dialysis/Hemodialysis	$50 copay per visit	30% coinsurance after medical deductible is met
Prescription Drugs *Dispensed in the office*	No charge	30% coinsurance after medical deductible is met
Surgery	$25 PCP/$50 Spec. copay per visit‡	30% coinsurance after medical deductible is met
Diagnostic Services		
Lab		
Office	$25 PCP/$50 Spec. copay per visit	30% coinsurance after medical deductible is met
Preferred Reference Lab	No charge	30% coinsurance after medical deductible is met
Outpatient Hospital	No charge	30% coinsurance after medical deductible is met
X-Ray		
Office	$25 PCP/$50 Spec. copay per visit	30% coinsurance after medical deductible is met
Outpatient Hospital	$50 copay per visit	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
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	$300 copay per visit	30% coinsurance after medical deductible is met
Outpatient Hospital	$300 copay per visit	30% coinsurance after medical deductible is met
Emergency and Urgent Care		
Urgent Care	$25 PCP/$50 Spec. copay per visit	30% coinsurance after medical deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$250 copay per visit	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	Covered as In-Network
Ambulance	$100 copay per trip	Covered as In-Network
Outpatient Mental Health and Substance Abuse		
Doctor Office Visit	$25 copay per visit	30% coinsurance after medical deductible is met
Facility Visit		
Facility Fees	$25 copay per visit	30% coinsurance after medical deductible is met
Doctor Services	No charge	30% coinsurance after medical deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	$300 copay per visit	30% coinsurance after medical deductible is met
Freestanding Surgical Center	$300 copay per visit	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 and Other Services		
Hospital	No charge	30% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	$350 copay per day to a maximum of $1,750 per admission	30% coinsurance after medical deductible is met
Doctor and other services	No charge	30% coinsurance after medical deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 90 visits per benefit period. Limits are combined for all home health services.*	No charge	30% coinsurance after medical deductible is met
Rehabilitation services *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.*		
Office	$25 copay per visit	30% coinsurance after medical deductible is met
Outpatient Hospital	$25 copay per visit	30% coinsurance after medical deductible is met
Cardiac rehabilitation Limit is combined In-Network and Non-Network across all outpatient settings.		
Office	$25 PCP/ $50 Spec. copay per visit	30% coinsurance after medical deductible is met
Outpatient Hospital	$50 copay per visit	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
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 100 days combined per admission. Limit is combined In-Network and Non-Network.*	No charge	30% coinsurance after medical deductible is met
Hospice	No charge	30% coinsurance after medical deductible is met
Durable Medical Equipment	No charge	30% coinsurance after medical deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period. Limit is combined In-Network and Non-Network.*	No charge	30% coinsurance after medical deductible is met
Hearing Aids *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.*	No charge	30% coinsurance after medical deductible is met
Autism Spectrum Disorder (ASD) Therapeutic Care: unlimited physical, occupational and speech Therapy. Applied Behavioral Analysis	**Office Visit: $25** for each visit **Outpatient Facility: $25** for each visit **20%** of the amount the health care professionals in our network have agreed to accept for their services	**30%** coinsurance after medical deductible is met **30%** coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	$150 person / $300 family	Not covered
Pharmacy Out-of-Pocket Limit	$4,100 person / $8,200 family	Not covered
Prescription Drug Coverage *Cost shares for drugs included on the Essential 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.*		
Home Delivery Pharmacy 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.		
Preventive Drugs *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.*		
Tier 1 Preventive - Typically Generic *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	No charge	Not covered (retail and home delivery)
Tier 2 Preventive - Typically Preferred Brand *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	No charge	Not covered (retail and home delivery)
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	$10 copay per prescription after Pharmacy deductible is met (retail and home delivery)	Not covered (retail and home delivery)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	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
Tier 3 - Typically Non-Preferred Brand *Per 30 day supply (retail pharmacy and Rx Maintenance 90 pharmacy).* *Per 90 day supply (home delivery).*	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)
Tier 4 - Typically Specialty (brand and generic) *Per 30 day supply (specialty pharmacy).*	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
This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.		
Children's Vision (up to age 19) **Child Vision Deductible**	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	$15 copay	Reimbursed Up to $30
Adult Vision (age 19 and older) **Adult Vision Deductible**	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	$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 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 4th 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:

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 (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (833) 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.

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Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'idiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih ninízingo kojį' 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.

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Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (833) 597-2358.

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It's important we treat you fairly
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