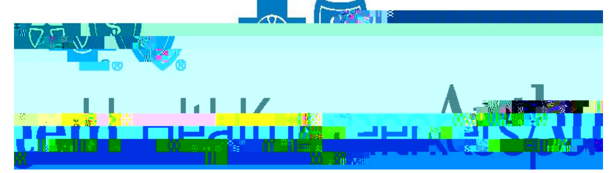
Your summary of benefits



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
subject to the Plan's terms and conditions, including Deductibles, Coinsurance, In Network dicounts and Allowable Charges, as s
the Plan Document. Therefore,

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 deductibl 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		
	$25 copay per visit	30% coinsurance after medical deductible is met

	Cost

.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

.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		

.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 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
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 National Direct drug list appear below. Your plan uses the Advantage Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies. If you sele drug when a generic drug is available, additional cost sharing amounts may apply. Drug cost share assistance be available for certain specialty drugs.		

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Home Delivery Pharmacy Maintenance medication are available through CarelonRx Home Delivery Pharmacy to call us on the number on your ID card to sign up when you first use the service.		
Preventive Drugs Your Pharmacy cost share is waived for drugs included on the VPCBC Preventive Rx drug li list of drugs for the treatment of diabetes, asthma, depression, heart health, high blood pressure, high choleste osteoporosis. This list is free of charge and are not subject to the deductible.		

Tier1 Preventive Typically Generic

Per 30 day.213 0 Td (d) Tj ppo 0.004 Tc 0 Tw (1) (r) (7) -3 (c) 15 (a) 7 -5.9 (I) 7 0 (I) -3.0 1 Tj (y)] TJ 0 12 Tw 0 2 Tw 3.6 Mtc] Tj 9 1 p (B) 1 S ( ) T [o