

# *Anthem HealthKeepers HMO*

<b>Covered Services</b>	<b>You Pay</b>
<b><i>Preventive Care Services</i></b>	
<p>Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.</p> <p>*During the course of a routine screening procedure, abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and your provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by your provider, which will result in a member cost share.</p>	<b>*No Charge</b>
<b><i>Routine Visit</i></b>	
<ul style="list-style-type: none"> <li>•annual routine eye exam</li> </ul>	<b>\$15 for each visit</b>
<b><i>Spinal Manipulation</i></b>	
<ul style="list-style-type: none"> <li>•spinal manipulation and manual medical therapy services (chiropractic care)</li> </ul> <p><b><i>Limited to 30 visits per plan year</i></b></p>	<b>\$25 for each visit</b>

## ***All Other Services***

You will pay all the costs associated with your care until you have paid \$1,000 in one plan year. This is known as your deductible.

- If two people are covered under your plan, each of you will pay the first \$1,000 of the cost of your care (\$2,000 total).

- If three or more people are covered under your plan, together you will pay the first \$2,000 of the cost of your care. However, the most one family member will pay is \$1,000.

***Once you reach your deductible you pay:***

<b>Doctor Visits</b>	
<ul style="list-style-type: none"> <li>•office visits</li> <li>•home visits</li> <li>•urgent care visits</li> <li>•in-office surgery</li> <li>•voluntary family planning</li> </ul>	<p><b>\$25</b> for each visit to your PCP</p> <p><b>\$50</b> for each visit to a specialist</p>
<b>Labs, Diagnostic X-rays and Other Outpatient Diagnostic Tests</b>	
<ul style="list-style-type: none"> <li>•diagnostic x-rays</li> <li>•lab work</li> <li>•other diagnostic test</li> </ul> <p><b>*A copay does not apply when these services are provided by the same provider on the same day as the office visit.</b></p>	<p><b>\$25</b> for each visit to your PCP*</p> <p><b>\$50</b> for each visit to a specialist*</p>
<ul style="list-style-type: none"> <li>•advanced diagnostic imaging services</li> </ul> <p><b>*Your payment responsibility are waived if services are billed as part of an emergency room visit.</b></p>	<p><b>\$150</b> for each visit*</p>
<b>Other Outpatient Services</b>	
<ul style="list-style-type: none"> <li>•hospice services</li> <li>•insulin pumps and oxygen</li> <li>•durable medical equipment</li> <li>•partial day mental health and substance abuse services</li> </ul>	<p><b>No Charge</b></p>
<ul style="list-style-type: none"> <li>•ambulance travel</li> </ul>	<p><b>\$100</b> per transport</p>
<ul style="list-style-type: none"> <li>•home health care services</li> </ul>	<p><b>\$50</b> per calender month</p>

**SPECIALIST VISITS DO NOT REQUIRE PCP REFERRAL.**

***For benefits listed with specific limits all services received during the plan year from October 1 - September 30 for that benefit are applied to that limit (whether received in or out-of-network). Your deductible amount begins anew on October 1 each year.***

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Covered Services	You Pay
<b>Other Outpatient Services (continued)</b>	
<ul style="list-style-type: none"> <li>•prosthetic devices</li> <li>•injectable medications* (excluding chemotherapy medications, allergy injections and serum dispensed in a physician's office)</li> </ul> <p><b>*You will also pay an additional \$25 or \$50 office visit copayment depending on the type of provider who treats you.</b></p>	<p><b>20%</b> of the amount the care professionals in our network have agreed to accept for their services</p>
<b>Therapy Services</b>	
<ul style="list-style-type: none"> <li>•occupational therapy**</li> <li>•physical therapy**</li> <li>•speech therapy**</li> </ul> <p><b>**Limited to 30 combined visits per plan year for physical therapy and occupational therapy services, and 30 visits per plan year for speech therapy services.</b></p>	<p><b>\$25</b> for each visit</p>
<ul style="list-style-type: none"> <li>•chemotherapy, radiation, cardiac and respiratory therapy</li> </ul>	<p><b>\$50</b> for each visit</p>
<ul style="list-style-type: none"> <li>•dialysis</li> </ul>	<p><b>\$50</b> per calendar month</p>
<b>Outpatient Infusion Services</b>	
<ul style="list-style-type: none"> <li>•<b>facility</b></li> </ul>	<p><b>\$50</b> for each visit</p>
<ul style="list-style-type: none"> <li>•<b>ambulatory Infusion Centers</b></li> </ul>	<p><b>\$50</b> per calendar month for IV services</p>
<ul style="list-style-type: none"> <li>•<b>home services</b></li> </ul>	<p><b>\$50</b> per calendar month for IV services</p>
<b>Outpatient Surgery in a Hospital or Facility</b>	
<ul style="list-style-type: none"> <li>•surgery</li> </ul>	<p><b>\$150</b> for each visit</p>
<b>Inpatient Stays in a Hospital or Facility</b>	
<ul style="list-style-type: none"> <li>•skilled nursing facility (100 days for each admission)</li> </ul>	<p><b>20%</b> of the amount the care professionals in our network have agreed to accept for their services</p>
<ul style="list-style-type: none"> <li>•semi-private room</li> <li>•intensive or coronary care unit</li> <li>•private room when approved in advance</li> </ul>	<p><b>\$300</b> per day (not to exceed <b>\$1,500</b>) for an admission</p>

<b>Maternity</b>	
•all routine outpatient pre- and postnatal care (excluding inpatient stays)	<b>\$300</b> per pregnancy
•diagnostic testing (such as ultrasounds, non-stress tests and other fetal monitor procedures)	<b>\$50</b> for each visit
<b>Outpatient Mental Health and Substance Abuse</b>	
•medication management •group therapy •individual therapy up to 30 minutes in length	<b>\$20</b> for each visit
•other mental and health substance abuse visits	<b>\$30</b> for each visit
<b>Emergency Care and Out of the Service Area Urgent Care</b>	
•urgent care visits	<b>\$50</b> for each visit
•true emergency care visits in our out of the service area <b>*Waived if admitted directly to the hospital</b>	<b>\$250</b> for each visit to an emergency room*
<b>Out-of-Pocket Maximums</b>	
<b>What You Will Pay for Covered Services in One Plan Year (October 1 - September 30)</b>	
<p>If you are the only one covered by your plan, you will pay \$4,000 for covered services outlined in this insert. Once you have reached this amount, your payment for the covered services outlined in this insert is \$0, except for services listed below.</p> <ul style="list-style-type: none"> <li>•If two people are covered under your plan, each of you will pay \$4,000 (\$8,000 total).</li> <li>•If three or more people are covered under your plan, together you will pay \$8000. However, no family member will pay more than \$4,000 toward the limit.</li> </ul> <p><b>The following do not count toward the plan year out-of-pocket maximum. You will still need to pay:</b></p> <ul style="list-style-type: none"> <li>•the costs associated with vision benefits</li> <li>•the cost of prescription drugs</li> <li>•the cost of dental benefits</li> <li>•the cost of care received when the benefit limits have been reached</li> </ul>	

Some benefits may be subject to balance billing, if provided by a non-participating provider. For more information on balance billing, see the enrollment brochure.

This benefits overview insert is only one piece of your entire enrollment package. See the enrollment brochure for a list of your plan's exclusions and limitations and applicable policy form numbers.