

## Anthem Blue Cross Blue Shield Health Healthkeepers 20/1000 (HMO)

**Effective Date: October 1, 2009**

Health Maintenance Organization (HMO) - The HealthKeepers HMO Plans provide rich benefits with fixed copays. The HealthKeepers Plans require the selection of a Primary Care Physician (PCP).

Covered Services	You Pay
<b>Preventive Care Services</b>	
Well child visits                      Pap Tests	<b>\$20</b> for each visit to your PCP*
Immunizations                          Mammograms	
Checkups                                  Screening Tests	
Gynecological exams                  Prostate exams	<b>\$40</b> for each visit to a specialist*
Prostate Specific Antigen (PSA) test	
*outpatient laboratory and pathology services/tests are covered at 100% when performed by an HMO laboratory provider ** Gynecological exams are covered with a PCP copay regardless of whether the member visits a PCP or specialist.	
<b>Routine Vision</b>	
Annual routine eye exam <b>Plus valuable discounts on eyewear</b>	<b>\$15</b> for each visit in-network, \$30 allowance for out-of-network
<b>Spinal Manipulation</b>	
Spinal manipulation and manual medical therapy services (chiropractic care) <b>Limited to 30 visits per calendar year</b>	<b>\$25</b> for each visit

## All Other Services

You will pay all the costs associated with your care until you have paid \$1,000 in one calendar 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.

<b>All Other Services (cont.)</b>	
<b>Once you reach your deductible you pay:</b>	
<b>Doctor Visits</b>	
Office visits Home visits Urgent care visits	In-house surgery Voluntary family planning
	<b>\$20</b> for each visit to your PCP  <b>\$40</b> for each visit to a specialist
<b>Labs, Diagnostic X-rays and Other Outpatient Diagnostic Tests</b>	
Diagnostic x-rays Lab work	Other diagnostic test
	<b>\$20</b> for each visit to your PCP  <b>\$40</b> for each visit to a specialist
<b>* A copay does not apply when these services are provided by the same provider on the same day as the office visit.</b>	
Advanced diagnostic imaging services <b>* Your payment responsibility is waived if services are billed as part of an emergency room visit.</b>	
	<b>\$150</b> for each visit*
<b>Other Outpatient Services</b>	
Hospice services Insulin pumps and oxygen Durable medical equipment (\$2,000 maximum) Partial day mental health & substance abuse services	No Charge
Ambulance travel	<b>\$100</b> per transport
Home health care services	<b>\$40</b> per calendar month

**Covered Benefits**

**You Pay**

<b>Other Outpatient Services (cont)</b>	
Prosthetic devices Injectable medications * (excluding chemotherapy medications, allergy injections and serum dispensed in a physician's office)  <i>* You will also pay an additional \$20 or \$40 of-office visit copayment depending on the type of provider who treats you.</i>	<b>20%</b> of the amount the health care professionals in our network have agreed to accept for their services
<b>Therapy Services</b>	
Occupational therapy      Speech therapy Physical therapy  <b>**Limited to 30 combined visits per calendar year for physical therapy and occupational therapy services, and 30 visits per calendar year for speech therapy services.</b>	<b>\$25</b> for each visit
Chemotherapy, radiation, cardiac and respiratory therapy	<b>\$40</b> for each visit
Dialysis	<b>\$40</b> per calendar month
<b>Outpatient Infusion Services</b>	
Facility	<b>\$40</b> for each visit
Ambulatory infusion centers	<b>\$40</b> per calendar month for IV services
Home services	<b>\$40</b> per calendar month for IV services
<b>Outpatient Surgery in a Hospital or Facility</b>	
Surgery*	<b>\$250</b> for each visit
<b>Inpatient Stays in a Hospital or Facility</b>	
Skilled nursing facility (100 days for each admission)	<b>20%</b> of the amount health care professionals in our network have agreed to accept for their services
Semi-private room Intensive or coronary care unit Private room when approved in advance	<b>\$300</b> per day (not to exceed <b>\$1,500</b> ) for an admission

<b>Maternity</b>	<b>You pay</b>
All routine outpatient pre and postnatal care (excluding inpatient stays)	<b>\$200</b> per pregnancy
Diagnostic testing (such as ultrasounds, non-stress tests and other fetal monitor procedures)	<b>\$40</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 health and substance abuse visits	<b>\$30</b> for each visit
<b>Emergency Care and Out of the Services Area Urgent Care</b>	
Urgent care visits	<b>\$40</b> for each visit
True emergency care visits in or out of the service area <i>* Waived if admitted directly to the hospital.</i>	<b>\$150</b> for each visit to an emergency room*
<b>Out-of-Pocket Maximums</b>	
<b>What You Will Pay for Covered Services in One Calendar Year (January 1-December 31)</b>	

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.

- If two people are covered under your plan, each of you will pay \$4,000 (\$8,000 total).
- If three or more people are covered under your plan, together you will pay \$8,000. However, no family member will pay more than \$4,000 toward the limit.

The following do not count toward the calendar year out-of-pocket maximum.

You will still need to pay:

- the costs associated with vision benefits
- the cost of prescription drugs
- the cost of dental benefits
- the cost of care received when the benefit limits have been reached

HEALTH INSURANCE	For HealthKeepers (employee pays)	
PRESCRIPTION DRUG	Up to 30-day Medication Supply	Up to 90-day Medication Supply
	<i>From Retail Pharmacy</i>	<i>Home Delivery Service</i>
Tier 1 Medications	\$10 copay	\$20 copay
Tier 2 Medications	\$30 copay after deductible	\$60 copay after deductible
Tier 3 Medications	\$50 or 20% of script cost	\$100 or 20% of script cost
Out-of-Pocket Maximum	\$3500 per member	

*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.*

**Monthly Healthkeepers 20/1000 Rates**

	Total Premium	County Portion	<b><u>Employee Portion</u></b>
Employee ONLY	\$438.76	\$435.00	<b>\$3.76</b>
Employee + 1 Child	\$571.25	\$435.00	<b>\$136.25</b>
Employee + Children	\$604.99	\$435.00	<b>\$169.99</b>
Employee + Spouse	\$759.92	\$490.00	<b>\$269.92</b>
FAMILY	\$864.27	\$490.00	<b>\$374.27</b>

For questions or claims please contact Customer Service at  
1.804.358.7390 or 1.800.421.1880  
Website: [www.anthem.com](http://www.anthem.com)

