Your Benefits

Anthem. HealthKeepers

Plan 10 - HMO

Your Anthem HealthKeepers Plan	
Care rendered in a health care professional's office:	
You will typically pay a set fee as noted below.	
Inpatient facility and most outpatient facility services:	
o You will pay all of the costs associated with your care until you have paid $300 in one calendar year. o If two people are covered under your plan, each of you will pay the first $300 of the cost of your care ($600 total). o If three or more people are covered under your plan, together you will pay the first $600 of your care. However, the most one family member will pay is $300. o The deductible is included in the out-of-pocket maximum. After you reach this amount, known as your deductible*, you will pay 20% of the amount that health care professionals in our network have agreed to accept for their services when services are received at a hospital or facility. ***This deductible does not apply to services that require a copay and outpatient facility services related to preventive care.*** **The deductible is the amount you are required to pay in a calendar year (January 1 to December 31) toward the cost of your care before coverage for certain benefits begins. Deductible does not apply to services with a copayment.*	

Covered Services	You Pay
Preventive Care Services	
o well-baby visits o immunizations o checkups o gynecological exams o Pap tests o screening tests o prostate exams o Prostate Specific Antigen (PSA) test o mammograms (annually age 35 and over)	**No charge,** deductible does not apply
Doctor Visits	
o office visits o home visits o urgent care visits o in-office surgery o voluntary family planning o allergy testing and injections	**$20** for each visit to your PCP **$40** for each visit to a specialist (deductible does not apply)
Labs, Diagnostic X-rays and Other Outpatient Diagnostic Test	
o diagnostic x-rays o lab work o diagnostic tests ****This fee is not required when these services are provided by the same professional on the same day as the office visit.***	**$20** for each visit to your PCP* **$40** for each visit to a specialist* (deductible does not apply to above visits); **20%** for each visit to a hospital or facility (after meeting deductible, except for services related to preventive care)
o complex diagnostic imaging services (requires pre-authorization) **** Your payment responsibility is waived if services are billed as a part of an emergency room visit.***	**20%** for each visit to a hospital or facility (after meeting deductible, except for services related to preventive care)
Other Outpatient Services	
o hospice services o insulin pumps and oxygen	**No charge**
o ambulance travel	**$100** per transport (deductible does not apply)
o dialysis	**$40** per calendar month (deductible does not apply)
o home health care services o durable medical equipment ($5,000 maximum)	**20%** of the amount the health care professionals in our network have agreed to accept for their services (after meeting the deductible)

For the benefits listed with specific limits, all services received during the calendar year from January 1 to December 31 for that benefit are applied to that limit. Covered services that are received during the last three months of the calendar year that are applied to your deductible may also be applied to the deductible required for the following year.

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Covered Services	You Pay
Therapy Service	
o occupational o physical o speech ***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.***	**$25** for each visit to a specialist's office (deductible does not apply to above); **20%** for each visit to a hospital or facility (after meeting deductible)
o chemotherapy o cardiac o radiation o respiratory	**$40** for each visit to a specialist's office (deductible does not apply to above); **20%** for each visit to a hospital or facility (after meeting deductible)
o spinal manipulation and manual medical therapy services (chiropractic care) ***Limited to 30 visits per calendar year.***	**$25** for each visit (deductible does not apply to above)
Outpatient Infusion Services	
o facility	**$40** for each visit (deductible does not apply to above)
o ambulatory infusion centers	**$40** per calendar month for IV services (deductible does not apply to above)
o home services	**$40** per calendar month for IV services (deductible does not apply to above)
Outpatient Surgery	
o outpatient surgery	**20%** for each visit to a hospital or facility (after meeting deductible, except for services related to preventive care)
Inpatient Stays in a Hospital or Facility (requires pre-authorization)	
o semi-private room (includes inpatient mental health/substance abuse admissions and maternity admissions) o private room when approved in advance o intensive or coronary care unit o skilled nursing facility (100 day maximum per confinement)	**20%** for each stay at a hospital or facility (after meeting deductible)
Maternity	
o initial visit to confirm pregnancy	**$20** for your PCP **$40** for a specialist (deductible does not apply to above)
o all routine pre- and postnatal office visits (excluding inpatient stays)	**$200** per pregnancy (deductible does not apply to above)
o diagnostic tests o non-stress tests and other fetal monitor procedures o ultrasounds	**$40** for each visit to a specialist's office (deductible does not apply to above); **20%** for each visit to a hospital or facility (after meeting deductible)
Outpatient Mental Health and Substance Abuse	
o medication management o individual therapy up to 30 minutes in length o group therapy	**$20** for each visit (deductible does not apply to above)
o other mental health and substance abuse visits	**$20** for your PCP **$40** for a specialist (deductible does not apply to above)
o partial day treatment programs	**20%** for each visit to a hospital or facility (deductible does not apply)

Routine Vision	
o an annual routine eye exam ***Plus valuable discounts on eyewear***	**$15** for each visit (deductible does not apply)
Emergency Care and Out of the Service Area Urgent Care	
o urgent care visit (out of the service area)	**$40** for each visit (deductible does not apply)
o true emergency care visits in or out of the service area	**20%** for each visit to an emergency room (after meeting deductible)

Out-of-Pocket Maximums

What You Will Pay for Covered Services in One Calendar Year (January 1 - December 31)

If you are the only one covered by your plan, you will pay $2,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is $0, except for services listed below.

- If two people are covered under your plan, each of you will pay $2,000 ($4,000 total).
- If three or more people are covered under your plan, together you will pay $4,000. However, no family member will pay more than $2,000 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

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.