Anthem HealthKeepers

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Covered Services	You Pay
Checkups and Sick Visits	
~ office visits ~ home visits ~ urgent care visits ~ in-office surgery ~ well baby visits ~ periodic checkup visits ~ prostate exams ~ immunizations ~ voluntary family planning	**$15** for each visit to your PCP **$35** for each visit to a specialist
Labs, Diagnostic X-rays and Other Outpatient Diagnostic Tests	
~ diagnostic x-rays ~ Prostate Specific Antigen (PSA) test ~ lab work ~ other diagnostic tests **A copay does not apply when these services are provided by the same provider on the same day as the office visit.*	**$15** for each visit to your PCP* **$35** for each visit to a specialist*
~ advanced diagnostic imaging services **Your payment responsibility is waived if services are billed as a part of an emergency room visit.*	**$150** for each visit*
Other Outpatient Services	
~ home health care services ~ hospice services ~ insulin pumps and oxygen ~ durable medical equipment ($2,000 maximum) ~ ambulance travel ~ partial day mental health and substance abuse services	**No Charge**
~ prosthetic devices ~ injectable medications* (excluding chemotherapy medications, allergy injections and serum dispensed in a physician's office) **You will also pay an additional $15 or $35 office visit copayment depending on the type of provider who treats you.*	**20%** of the amount the health care professionals in our network have agreed to accept for their services
Therapy Services	
~ occupational therapy** ~ physical therapy** ~ speech therapy** ***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
~ chemotherapy, radiation, IV and respiratory therapy ~ dialysis* **Only one payment is required for all dialysis treatments that occur within a calendar month.*	**$35** for each visit
~ spinal manipulation and manual medical therapy services (chiropractic care) *Limited to up to 30 visits per calendar year.*	**$25** for each visit
Outpatient Surgery in a Hospital or Facility	
~ surgery	**$150** for each visit
Inpatient Stays in a Hospital or Facility	
~ skilled nursing facility (100 day maximum per illness or condition)	**No Charge**
~ semi-private room ~ intensive or coronary care unit ~ private room when approved in advance	**$200** per day (not to exceed **$1,000**) for an admission

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	You Pay
Routine Annual Gynecological Exam	
~ pelvic exam ~ breast exam ~ Pap test	**$15** for each visit to your PCP or to a specialist
Maternity	
~ all routine outpatient pre- and postnatal care (excluding inpatient stays)	**$100** per pregnancy
~ diagnostic testing (such as ultrasounds, non-stress tests and other fetal monitor procedures)	**$35** for each visit
Mammograms	
~ one baseline mammography screening for members age 35-39 ~ an annual mammogram for members age 40 and older or as often as deemed medically necessary	**$15** for each visit to your PCP or **$35** for each visit to a specialist or facility
Outpatient Mental Health and Substance Abuse	
~ medication management ~ individual therapy up to 30 minutes in length ~ group therapy	**$20** for each visit
~ other mental health and substance abuse visits	**$30** for each visit
Routine Vision	
~ annual routine eye exam *If you go to an eye care professional not in our network for your routine eye examination, we will pay $30 and you will pay the rest of what the professional charges.* ***Plus valuable discounts on eyewear***	**$15** for each visit
Emergency Care and Out of the Service Area Urgent Care	
~ urgent care visits	**$35** for each visit
~ true emergency care visits in or out of the service area **Waived if admitted directly to the hospital.*	**$150** for each visit to an emergency room*

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 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 $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

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.