This benefit summary is not to be distributed without also providing access to the applicable Anthem HealthKeepers enrollment brochure

Anthem HealthKeepers

Anthem HealthKeepers 15 POS Open Access

Covered Services	You Pay
Preventive Care Services	
Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits. *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.	***No Charge**
Doctor Visits	
o office visits o home visits o in-office surgery o voluntary family planning	**$15** for each visit to your PCP **$35** for each visit to a specialist
o online visits (https://livehealthonline.com)	**$10** for each visit
Labs, Diagnostic X-rays and Other Outpatient Diagnostic Tests	
o diagnostic x-rays o diagnostic tests o lab work ***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
o advanced diagnostic imaging services	**20%** of the amount the health care professionals in our network have agreed to accept for their services
Autism Spectrum Disorder (ASD) – For children from age 2 through 10	
o diagnosis and treatment of autism spectrum disorder including: o behavioral health treatment* o psychiatric care o therapeutic care** o pharmacy care o psychological care * ***Mental Health Services*** *****Unlimited physical, occupational and speech therapy.***	Member cost shares will be dependent on the services rendered.
o applied behavioral analysis o limited to a $35,000 per member annual maximum	**20%** of the amount the health care professionals in our network have agreed to accept for their services
Early Intervention – For children from birth up to age 3	
o Unlimited per member per calendar year up to age 3	Member cost shares will be dependent on the services rendered.
Other Outpatient Services	
o hospice care	**No Charge**
o diabetic supplies, equipment and education	Member cost shares will be dependent on the services rendered.
o ambulance travel	**$150** per transport
o prosthetic devices o durable medical equipment o home health care (100 visits) o injectable medication* (excluding immunizations, preventive care, 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

Your benefit period may be a calendar year or a plan year. A calendar year means your benefit period runs from January through December while a plan year runs from the effective date of the plan through a 12-month period (e.g. February 1 through January 31 or July 1 through June 30). Check with your employer to learn whether your benefits will be calculated on a calendar year or plan year basis.

For benefits listed with specific limits all services received in the calendar year or plan year for that benefit are applied to that limit (whether received in or out-of- network).

Covered Services	You Pay
Therapy Services	
o physical and occupational therapy (30 combined visits)* o spinal manipulation and manual medical therapy services (30 visit limit) o speech therapy (30 visit limit)* ***Limit does not apply to Autism Spectrum Disorder.**	**$25** for each visit
o chemotherapy, radiation, cardiac and respiratory therapy	**$35** for each visit
o dialysis	**20%** of the amount the health care professionals in our network have agreed to accept for their services
Outpatient Therapy Services in a Hospital or Facility	
o physical and occupational therapy (30 combined visits)* o speech therapy (30 visit limit)* * ***Limit does not apply to Autism Spectrum Disorder.***	**20%** of the amount the health care professionals in our network have agreed to accept for their services
Outpatient Infusion Services	
o facility o ambulatory infusion centers o home services	**$35** for each visit
Outpatient Surgery in a Hospital or Facility	
o surgery	**$200** for each visit
Inpatient Stays in a Hospital or Facility	
o semi-private room o private room when approved when approved in advance o intensive or coronary care unit ***You do not have to pay another inpatient copay if you are readmitted for the same or related condition within less than 72 hours from when you went home.**	**$250** per day (not to exceed **$1250**) for an admission*
o skilled nursing facility (100 days for each admission)	**20%** of the amount the health care professionals in our network have agreed to accept for their services
Maternity	
o all routine pre- and postnatal care (excluding inpatient stays)	**$300** per pregnancy
o diagnostic testing (such as ultrasounds, non-stress tests and other fetal monitor procedures)	**$35** for each visit
Outpatient Mental Health and Substance Use	
o Outpatient facility(partial day mental health and substance use services)	**No charge**
o office visit	**$15** for each visit
o outpatient facility professional provider services	**$30** for each visit
Routine Vision	
o an annual routine eye exam ***Plus valuable discounts on eyewear***	**$15** for each visit
Emergency Care and Urgent Care	
o urgent care visits	**$35** for each visit
o emergency care visits in or out of the service area ***Waived if admitted directly to the hospital.**	**$250** for each visit to an emergency room*

Out-of-Plan Services

Deductible for services received from out-of-plan health care professionals

You will pay all of the costs associated with covered services until you pay $400 in one calendar year. If two or more people are covered under your health plan, each member will be responsible for paying the first $400 toward covered services within a calendar year.

- If two people are covered under your plan, each of you will pay the first $400 of the cost of your care ($800 total).
- If three or more people are covered under your plan, together you will pay the first $800 of the cost of your care. However, the most one family member will pay is $400.

Once this amount has been reached, we will pay 70% of the amount doctors, hospitals and other health care professionals have agreed to accept for the same covered services.

If you go to an eye care professional not in our network for your routine eye examination, we will pay $30 (whether or not you have reached the $400 calendar year out-of-plan deductible) and you will pay the rest of what the professional charges.

In addition, you may seek spinal manipulation and manual medical therapy services (chiropractic care) from a provider not in our network without first meeting the out-of-plan deductible.

Out-of-Pocket Maximums

What You Will Pay for Covered Services in One Calendar Year or Plan Year

When using in-plan professionals

If you are the only one covered by your plan, you will pay $3,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is $0, except for those services listed below that do not count toward the annual out-of-pocket maximum.

- If two people are covered under your plan, each of you will pay $3,000 ($6,000 total).
- If three or more people are covered under your plan, together you will pay $6,000. However, no family member will pay more than $3,000 toward the limit.

When using out-of-plan professionals

If you are the only one covered by your plan, you will pay $5,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is $0, except for those services listed below that do not count toward the annual out-of-pocket maximum.

- If two people are covered under your plan, each of you will pay $5,000 ($10,000 total).
- If three or more people are covered under your plan, together you will pay $10,000. However, no family member will pay more than $5,000 toward the limit.

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

- your share of the cost of adult routine vision care
- the cost of care received when the benefit limits have been reached
- the cost of services and supplies not covered under your benefits
- the additional amount health care professionals not in our network may bill you when their charge is more than what we pay

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 summary of benefits is a brief outline of coverage, designed to help you with the selection process. This policy has exclusions and limitations to benefits and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact your insurance agent or contact us. *If there is a difference between this summary and the contract of coverage, the contract of coverage will prevail.*

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits