# Your Benefits

Anthem HealthKeepers

## *Anthem HealthKeepers 15*

| 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.<br><br>*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 in-office surgery<br>o urgent care visits o voluntary family planning<br>o home visits | **$15** for each visit to your PCP<br>**$35** for each visit to a specialist |
| **Labs, Diagnostic X-rays and Other Outpatient Diagnostic Tests** | |
| o diagnostic x-rays o lab work o diagnostic tests<br><br>***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<br>**$35** for each visit to a specialist |
| o advanced diagnostic imaging services<br>***Your payment responsibility is waived if services are billed as a part of an emergency room visit.*** | **$150** for each visit |
| **Other Outpatient Services** | |
| o hospice services o partial day mental health and substance abuse services<br>o insulin pumps and oxygen o durable medical equipment | **No Charge** |
| o ambulance travel | **$100** per transport |
| o home health care services | **$35** per calendar month |
| o prosthetic devices<br>o injectable medications* (excluding chemotherapy medications, allergy injections and serum dispensed in a physician's office)<br>***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** | |
| o occupational therapy o speech therapy<br>o physical therapy<br>***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 |
| o chemotherapy, radiation, cardiac and respiratory therapy | **$35** for each visit |
| o dialysis | **$35** per calendar month |
| o spinal manipulation and manual medical therapy services<br>***Limited to 30 visits per calendar year.*** | **$25** for each visit |

***For 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.***

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|---|---|
| **Outpatient Infusion Services** | |
| o facility | **$35** for each visit |
| o ambulatory Infusion Centers | **$35** per calendar month for IV services |
| o home services | **$35** per calendar month for IV services |
| **Outpatient Surgery in a Hospital or Facility** | |
| o surgery | **$150** for each visit |
| **Inpatient Stays in a Hospital or Facility** | |
| o skilled nursing facility (100 days for each admission) | **20%** of the amount network health care professionals have agreed to accept for their services |
| o semi-private room<br>o private room when approved when approved in advance<br>o intensive or coronary care unit | **$200** per day (not to exceed **$1,000**) for an admission |
| **Maternity** | |
| o all routine outpatient pre- and postnatal care (excluding inpatient stays) | **$100** 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 Abuse** | |
| o medication management<br>o individual therapy up to 30 minutes in length<br>o group therapy | **$20** for each visit |
| o other mental health and substance abuse visits | **$30** for each visit |
| **Routine Vision** | |
| o annual routine eye exam<br><br>***Plus valuable discounts on eyewear*** | **$15** for each visit |
| **Emergency Care and Out of the Service Area Urgent Care** | |
| o urgent care visits | **$35** for each visit |
| o true emergency care visits in our out of the service area<br>***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.

o If two people are covered under your plan, each of you will pay $2,000 ($4,000 total).

o 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:**

o the costs associated with vision benefits

o the cost of prescription drugs

o the cost of dental benefits

o 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.*

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.

HealthKeepers, Inc. believes this plan is a ''grandfathered health plan'' under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections of the Affordable Care Act apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to HealthKeepers, Inc. at the telephone number printed on the back of your member identification card, or contact your group benefits administrator if you do not have an identification card. For ERISA plans, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1–866–444–3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For nonfederal governmental plans, you may also contact the U.S. Department of Health and Human Services at www.healthcare.gov.