

Brief summary of benefits comparing HealthKeepers 15 HMO to HealthKeepers 15 POS - Changes in Red

Covered Services	HealthKeepers HMO 15 Plan (Anthem BCBS)	HealthKeepers POS 15 Plan (Anthem BCBS)
Calendar Year Deductible (Ded.) (Individual/Family)	None	None
Your Maximum Out-of-Pocket Expense Limit Per Cal. Year	\$2,000 Individual / \$4,000 Family	\$2,000 Individual / \$4,000 Family
Referrals to Specialists by PCPs Required?	Yes	Yes
Physician Office Visits	PCP - \$15 copay Specialist - \$ 35 copay	PCP - \$15 copay Specialist - \$ 35 copay
Diagnostic Labs, X-rays, and Other Outpatient Diagnostic Tests	PCP - \$15 copay Specialist - \$ 35 copay Separate copays are not charged for services/x-rays/tests provided by same provider on same day as office visit	PCP - \$15 copay Specialist - \$ 35 copay Separate copays are not charged for services/x-rays/tests provided by same provider on same day as office visit
Advanced Diagnostic Services	\$150 copay	20% coinsurance
Outpatient Surgery	\$150 copay	\$150 copay
Well Child Care	No charge	No charge
Adult Preventive Care	No charge	No charge
Maternity Care - Outpatient (Refer to Inpatient Hospital Services below for inpatient maternity benefits)	Routine pre and postnatal care (excluding inpatient stays) - \$100 copay per pregnancy Diagnostic testing such as ultrasounds, non-stress tests, and other fetal monitor procedures: \$35 copay	Routine pre and postnatal care (excluding inpatient stays) - \$150 copay per pregnancy Diagnostic testing such as ultrasounds, non-stress tests, and other fetal monitor procedures: \$35 copay
Urgent Care Center	\$35 copay (\$15 copay if urgent care designated as PCP)	\$35 copay (\$15 copay if urgent care designated as PCP)
Emergency Room Visit	\$150 copay	\$200 copay
Ambulance Travel	\$100 copay per transport	\$150 copay per transport
Dialysis Treatments	\$35 copay per month	20% coinsurance
Home Care Services	\$35 copay per month	20% coinsurance
Prosthetic Devices	20% coinsurance	20% coinsurance
Durable Medical Equipment	Covered in full	20% coinsurance
Outpatient Physical, Speech, Occupational Therapy	\$25 copay 30 visits combined per calendar year for physical and occupational therapy; 30 visits per calendar year for speech therapy	\$25 copay 30 visits combined per calendar year for physical and occupational therapy; 30 visits per calendar year for speech therapy
Cardiac-Rehab. Therapy	\$35 copay	\$35 copay
Respiratory Therapy	\$35 copay	\$35 copay
Chemotherapy	\$35 copay	\$35 copay
Radiation Therapy	\$35 copay	\$35 copay
Autism Spectrum Disorder (Children age 2 through 6)	Not covered	Diagnosis and Treatment - Cost share based on services rendered Applied Behavioral Analysis - 20% to \$35,000 limit per member per year
Inpatient Hospital Services	\$200 per day not to exceed \$1,000 for each admission	\$200 per day not to exceed \$1,000 for each admission
Skilled Nursing Facility Stays	20% coinsurance; 100-day per stay limit	20% coinsurance; 100-day per stay limit
Outpatient Mental Health and Substance Abuse (MHSA)	\$20 copay per visit for medication management, group/individual therapy \$30 copay for other visits	\$20 copay per visit for medication management, group/individual therapy \$30 copay for other visits
Inpatient MHSA Services	\$200 per day not to exceed \$1,000 for each admission	\$200 per day not to exceed \$1,000 for each admission
Chiropractic Services	\$25 copay per visit (PCP referral required) Limited to 30 visits per calendar year	\$25 copay per visit (PCP referral required) Limited to 30 visits per calendar year
Routine Vision Services	Annual eye exam - \$15 copay in network Discounts on eye wear and laser vision correction surgery \$30 allowance if you use non-network vision provider	Annual eye exam - \$15 copay in network Discounts on eye wear and laser vision correction surgery \$30 allowance if you use non-network vision provider
RX Retail Copays:	\$8/\$15/\$30	\$8/\$15/\$30
RX Mail Order Copays:	\$8/\$30/\$90	\$8/\$30/\$90
Out-of-Network Benefits	None	Calendar Year Deductible: \$400 / \$800 Calendar Year Out-of-Pocket Limit: \$4,000 / \$8,000 Coinsurance: 30% Coinsurance