

## Anthem HealthKeepers 25/30

Typically when you receive your care in a health care professional's office, you will pay a set fee as noted below. When services are received at a hospital or facility, you will pay 30% of the cost that the network hospital or facility has agreed to accept for their services.

Covered Services	You Pay
<b>Preventive Care</b>	
<ul style="list-style-type: none"> <li>○ well-child visits</li> <li>○ immunizations</li> <li>○ checkups</li> <li>○ gynecological exams*</li> </ul> <p><i>*Gynecological exams are covered with a PCP copay regardless of whether the member visits a PCP or specialist.</i></p>	<p>\$25 for each visit to your PCP \$50 for each visit to a specialist 30% for each visit to a hospital or facility</p>
<ul style="list-style-type: none"> <li>○ Pap tests</li> <li>○ mammograms</li> <li>○ prostate exams</li> </ul>	
<b>Labs, Diagnostic X-rays and Other Outpatient Diagnostic Tests</b>	
<ul style="list-style-type: none"> <li>○ screening tests</li> <li>○ Prostate Specific Antigen (PSA) test</li> </ul>	<p>\$25 for each visit to your PCP* \$50 for each visit to a specialist 30% for each visit to a hospital or facility</p>
<ul style="list-style-type: none"> <li>○ advanced diagnostic imaging services</li> </ul> <p><i>Your payment responsibility is waived if services are billed as a part of an emergency room visit.</i></p>	<p>\$150 for each visit 30% for each visit to a hospital or facility</p>
<b>Other Outpatient Services</b>	
<ul style="list-style-type: none"> <li>○ hospice services</li> <li>○ insulin pumps and oxygen</li> </ul>	No Charge
○ durable medical equipment (\$2,000 maximum)	
○ ambulance travel	\$100 per transport
○ home health care services	\$50 per calendar month
<ul style="list-style-type: none"> <li>○ dialysis*</li> </ul> <p><i>*Only one payment is required for all dialysis treatments that occur within a calendar month</i></p>	\$50 per calendar month
○ prosthetic devices	30% of the amount the health care professionals in our network have agreed to accept for their services
<ul style="list-style-type: none"> <li>○ injectable medications* (excluding chemotherapy medications, allergy injections and serum dispensed in a physician's office)</li> </ul> <p><i>*You will also pay an additional \$25 or \$50 office visit copayment depending on the type of provider who treats you.</i></p>	20% of the amount the health care professionals in our network have agreed to accept for their services
<b>Therapy Service</b>	
<ul style="list-style-type: none"> <li>○ occupational*</li> <li>○ physical*</li> </ul> <p><i>*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.</i></p>	<p>\$25 for each visit to a specialist 30% for each visit to a hospital or facility</p>
<ul style="list-style-type: none"> <li>○ chemotherapy</li> <li>○ radiation</li> </ul> <p><i>Only one payment is required for intravenous services that occur within a calendar month when rendered at home or an ambulatory infusion center.</i></p>	<p>\$50 for each visit to a specialist 30% for each visit to a hospital or facility</p>
<ul style="list-style-type: none"> <li>○ intravenous</li> <li>○ respiratory</li> </ul>	
<ul style="list-style-type: none"> <li>○ spinal manipulation and manual medical therapy services (chiropractic care)</li> </ul> <p><i>Limited to 30 visits per calendar year.</i></p>	\$25 for each visit

For benefits listed with specific limits all services received during the calendar year from January 1 and December 31 for that benefit are applied to that limit.

Covered Services	You Pay
<b>Outpatient Surgery in a Hospital or Facility</b>	
<ul style="list-style-type: none"> <li>○ surgery</li> </ul>	30% for each visit to a hospital or facility
<b>Inpatient Stays in a Hospital or Facility</b>	
<ul style="list-style-type: none"> <li>○ semi-private room</li> <li>○ skilled nursing facility (100 days for each admission)</li> <li>○ private room when approved when approved in advance</li> <li>○ intensive or coronary care unit</li> </ul>	30% for each visit to a hospital or facility
<b>Gynecological Exams</b>	
<ul style="list-style-type: none"> <li>○ pelvic exams</li> <li>○ breast exams</li> <li>○ Pap tests</li> </ul>	\$25 for each visit to your PCP or a specialist
<b>Mammograms</b>	
	\$25 for each visit to your PCP \$50 for each visit to a specialist 30% for each visit to a hospital or facility
<b>Maternity</b>	
<ul style="list-style-type: none"> <li>○ all routine outpatient pre- and postnatal care (excluding inpatient stays)</li> </ul>	\$300 per pregnancy
<ul style="list-style-type: none"> <li>○ diagnostic tests</li> <li>○ ultrasounds</li> <li>○ non-stress tests and other fetal monitor procedures</li> </ul>	\$50 for each visit to a specialist 30% for each visit to a hospital or facility
<b>Outpatient Mental Health and Substance Abuse</b>	
<ul style="list-style-type: none"> <li>○ medication management</li> <li>○ individual therapy up to 30 minutes in length</li> <li>○ group therapy</li> </ul>	\$20 for each visit
<ul style="list-style-type: none"> <li>○ other mental health and substance abuse visits</li> </ul>	\$30 for each visit
<ul style="list-style-type: none"> <li>○ partial day treatment programs</li> </ul>	30% for each visit to a hospital or facility
<b>Routine Vision</b>	
<ul style="list-style-type: none"> <li>○ annual routine eye exam</li> </ul> <p><i>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</i></p>	\$15 for each visit
<b>Emergency Care and Out of the Service Area Urgent Care</b>	
<ul style="list-style-type: none"> <li>○ urgent care visits</li> </ul>	\$50 for each visit
<ul style="list-style-type: none"> <li>○ true emergency care visits in or out of the service area</li> </ul>	30% for each visit to an emergency room

Out-of-Pocket Maximums
<b>What You Will Pay for Covered Services in One Calendar Year (January 1 - December 31)</b>
<p>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 the covered services outlined in this insert is \$0, except for services listed below.</p> <ul style="list-style-type: none"> <li>○ If two people are covered under your plan, each of you will pay \$3,000 (\$6,000 total).</li> <li>○ 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.</li> </ul> <p><b>The following do not count toward the calendar year out-of-pocket maximum. You will still need to pay:</b></p> <ul style="list-style-type: none"> <li>○ the costs associated with vision benefits</li> <li>○ the cost of prescription drugs</li> <li>○ the cost of dental benefits</li> <li>○ the cost of care received when the benefit limits have been reached</li> </ul>

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.