

Anthem HealthKeepers 25 POS Option 1 (2-50 Employees)

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	
<ul style="list-style-type: none"> ○ office visits ○ home visits ○ urgent care visits <input type="checkbox"/> ○ voluntary family planning ○ in-office surgery 	\$25 for each visit to your PCP \$50 for each visit to a specialist
Labs, Diagnostic X-rays and Other Outpatient Diagnostic Tests	
<ul style="list-style-type: none"> ○ diagnostic tests ○ diagnostic x-rays ○ lab work <i>*This fee is not required when these services are provided by the same professional on the same day as the office visit.</i>	\$25 for each visit to your PCP \$50 for each visit to a specialist
<ul style="list-style-type: none"> ○ advanced diagnostic imaging services 	20% of the amount the health care professionals in our network have agreed to accept for their services
Early Intervention – For children from birth through age 2	
<ul style="list-style-type: none"> ○ limited to a \$5,000 per member annual maximum* <i>*Unlimited physical, occupational and speech therapy</i>	Member cost shares will be dependent on the services rendered.
Other Outpatient Services	
<ul style="list-style-type: none"> ○ hospice care 	No Charge
<ul style="list-style-type: none"> ○ diabetic supplies, equipment and education 	Member cost shares will be dependent on the services rendered.
<ul style="list-style-type: none"> ○ ambulance travel 	\$150 per transport
<ul style="list-style-type: none"> ○ prosthetic devices ○ home health care (100 visits) ○ durable medical equipment ○ injectable medication* (excluding immunizations, preventive care, allergy injections and serum dispensed in a physician's office) <i>*You will also pay an additional \$25 or \$50 office visit copayment depending on the type of provider who treats you.</i>	20% of the amount the health care professionals in our network have agreed to accept for their services
Therapy Services	
<ul style="list-style-type: none"> ○ physical and occupational therapy (30 combined visits)* ○ speech therapy (30 visit limit)* ○ spinal manipulation and manual medical therapy services (30 visit limit) <i>*Limit does not apply to Early Intervention.</i>	\$25 for each visit
<ul style="list-style-type: none"> ○ chemotherapy, radiation, cardiac and respiratory therapy 	\$50 for each visit
<ul style="list-style-type: none"> ○ dialysis 	20% of the amount health care professionals in our network have agreed to accept for their services

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 (whether received in or out-of-plan).

Covered Services	You Pay
Outpatient Infusion Services	
<ul style="list-style-type: none"> o facility o ambulatory infusion centers 	\$50 for each visit
<ul style="list-style-type: none"> o home services 	20% of the amount health care professionals in our network have agreed to accept for their services
Outpatient Surgery in a Hospital or Facility	
<ul style="list-style-type: none"> o surgery 	\$300 for each visit
Inpatient Stays in a Hospital or Facility	
<ul style="list-style-type: none"> o semi-private room o private room when approved when approved in advance o intensive or coronary care unit <p>*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.</p>	\$350 per day (not to exceed \$1,750) for an admission*
<ul style="list-style-type: none"> o skilled nursing facility (100 days for each admission) 	20% of the amount health care professionals in our network have agreed to accept for their services
Maternity	
<ul style="list-style-type: none"> o all routine pre- and postnatal care (excluding inpatient stays) 	\$300 per pregnancy
<ul style="list-style-type: none"> o diagnostic testing (such as ultrasounds, non-stress tests and other fetal monitor procedures) 	\$50 for each visit
Outpatient Mental Health and Substance Abuse	
<ul style="list-style-type: none"> o partial day mental health and substance abuse services 	No charge
<ul style="list-style-type: none"> o medication management o individual therapy up to 30 minutes in length o group therapy 	\$20 for each visit
<ul style="list-style-type: none"> o other mental health and substance abuse visits 	\$30 for each visit
Routine Vision	
<ul style="list-style-type: none"> o an annual routine eye exam <p>Plus valuable discounts on eyewear</p>	\$15 for each visit
Emergency Care and Out of the Service Area Urgent Care	
<ul style="list-style-type: none"> o urgent care visits 	\$50 for each visit
<ul style="list-style-type: none"> o true emergency care visits in or out of the service area <p>*Waived if admitted directly to the hospital.</p>	\$250 for each visit to an emergency room*

Out-of-Plan Services
Deductible for services received from out-of-plan health care professionals
<p>You will pay all of the costs associated with covered services until you pay \$1,000 in one calendar year. If two or more people are covered under your health plan, each member will be responsible for paying the first \$1,000 toward covered services within a calendar year.</p> <ul style="list-style-type: none"> o If two people are covered under your plan, each of you will pay the first \$1000 of the cost of your care (\$2,000 total). o If three or more people are covered under your plan, together you will pay the first \$2,000 of the cost of your care. However, the most one family member will pay is \$1,000. <p>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.</p> <p>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 \$1,000 calendar year out-of-plan deductible) and you will pay the rest of what the professional charges.</p> <p>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.</p>