Your Anthem Benefits

Anthem

Anthem KeyCare 10 Plan

In-Network 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**
Routine Vision	
o annual routine eye exam ***Plus valuable discounts on eyewear***	**$15** for each visit
Doctor Visits	
o office visits o urgent care visits o home visits o in-office surgery o physical and occupational therapy in an office setting (30 combined visits)* o speech therapy visits in an office setting (30 visit limit)* o spinal manipulations and other manual medical intervention visits (30 visit limit) ***Limit does not apply to Early Intervention and Autism Spectrum Disorder.***	**$10** for each visit to a PCP **$20** for each visit to a specialist
Autism Spectrum Disorder (ASD) – For children from age 2 through 6	
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 through age 2	
o limited to a $5,000 per member annual maximum* ****Unlimited physical, occupational and speech therapy***	Member cost shares will be dependent on the services rendered.
Labs, Diagnostic X-rays and Other Outpatient Services	
o diagnostic lab services o diagnostic x-rays o dialysis o infusion services o shots and therapeutic injections, including infusion medications o chemotherapy (not given orally), radiation, cardiac and respiratory therapy	**10%** of the amount the health care professionals in our network have agreed to accept for their services
o durable medical equipment o medical appliances, supplies and medications	**20%** of the amount the health care professionals in our network have agreed to accept for their services
o ambulance travel	**$100** per transport
o diabetic supplies, equipment and education	Member cost shares will be dependent on the services rendered.

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-network).

In-Network Services	You Pay
Outpatient Visits in a Hospital or Facility	
o physical therapy and occupational therapy (30 combined visits)* o speech therapy (30 visit limit)* ***Limit does not apply to Early Intervention and Autism Spectrum Disorder.***	**$20 plus 10%** of the amount the health care professionals in our network have agreed to accept for their services
o surgery ***For the services billed by the doctor, you will pay an additional $10 or $20 depending on the type of doctor who treats you.***	**$100 plus 10%** of the amount the health care professionals in our network have agreed to accept for their services*
Emergency Care	
o emergency room	**$150 plus 10%** of the amount the health care professionals in our network have agreed to accept for their services*
o emergency room physician services	**10%** of the amount the health care professionals in our network have agreed to accept for their services
Mental Health and Substance Abuse Outpatient Services	
o office visits	**$10 per visit**
o outpatient facility (including partial day mental health and substance abuse services) o outpatient facility professional provider services	**10%** of the amount the health care professionals in our network have agreed to accept for their services
Care at Home	
o hospice care	**No charge**
o home health care (100 visits)	**10%** of the amount the health care professionals in our network have agreed to accept for their services
o private duty nursing ($500 maximum)* ***Since there is no network for this service, you may be billed for the difference between what we pay for this service and the amount the private duty nursing service charged.***	**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)	**$150** per pregnancy
o diagnostic test o non-stress tests and other fetal monitor procedures o ultrasounds	**10%** of the amount the health care professionals in our network have agreed to accept for their services
Inpatient Stays in a Network Hospital or Facility	
o semi-private room, intensive care or similar unit ***You do not have to pay another inpatient copay if you are readmitted for the same or related condition within 90 days of the day you went home.***	**$200 plus 10%** of the amount the health care professionals in our network have agreed to accept for their services*
o physician, nursing and other medically necessary professional services in the hospital including anesthesia, surgical and maternity delivery services o skilled nursing facility care (100 days for each admission)	**10%** of the amount the health care professionals in our network have agreed to accept for their services

Out-of-Network Services

Using Doctors, Hospitals and Other Health Care Professionals not Contracted to Provide Benefits

It's important to remember that health care professionals not in our network can charge whatever they want for their services. If what they charge is more than the fee our network health care professionals have agreed to accept for the same service, they may bill you for the difference between the two amounts. You will pay all the costs associated with the covered services outlined in this insert until you have paid $200 in one calendar year. This is called your out-of-network deductible.

- If two people are covered under your plan, each of you will pay the first $200 of the cost of your care ($400 total).
- If three or more people are covered under your plan, together you will pay the first $400 of the cost of your care. However, the most one family member will pay is $200.

Once you have reached this amount, when you receive covered services we will pay 70% of the fee our network health care professionals have agreed to accept for the same service. You will pay the rest, including any difference between the fee our network health care professionals have agreed to accept for the same service and the amount the health care professional not in our network charges. 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 $200 out-of-network deductible) and you will pay the rest of what the professional charges.

Out-of-Pocket Maximums

What You Will Pay for Covered Services in One Calendar Year (January 1 - December 31)

When using network professionals

If you are the only one covered by your plan, you will pay $1,500 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 $1,500 ($3,000 total).
- If three or more people are covered under your plan, together you will pay $3,000. However, no family member will pay more than $1,500 toward the limit.

When not using network 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.

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

- your share of the cost of prescription drugs and 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 Anthem KeyCare 10 plan
- the additional amount health care professionals not in our network may bill you when their charge is more than what we pay

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.