Your Anthem Benefits

Anthem KeyCare 15 Plus

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 pre- and postnatal office 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)* * Limited to 30 combined visits per calendar year for physical therapy and occupational therapy services, and 30 separate visits each per calendar year for speech therapy and spinal manipulation services. ** If your physician submits one bill for prenatal, delivery, and postnatal care, services are covered as maternity delivery services. (See Inpatient stay section.)	**$15** for each visit to a family or general practitioner, internist or pediatrician **$30** for each visit to a specialist
Labs, X-rays and Other Outpatient Services	
o lab services o Pap tests o Prostate Specific Antigen (PSA) tests o screening tests o infusion services o shots and therapeutic injections o dialysis o chemotherapy o radiation and respiratory therapy	**No charge**
o diagnostic x-rays	**$30** for each visit*
o advanced diagnostic imaging services ***Your payment responsibility is waived if services are billed as part of an emergency room visit.***	**$150** for each visit*
o medical appliances, supplies and medications, including infusion medications o durable medical equipment o professional ground ambulance services	**20%** of the amount of the health care professionals in our network have agreed to accept for their services
Outpatient Visits in a Hospital or Facility	
o physical therapy and occupational therapy (30 combined visits)* o speech therapy (30 visit limit)* * Limited to 30 combined visits per calendar year for physical therapy and occupational therapy services, and 30 separate visits each per calendar year for speech therapy and spinal manipulation services.	**$30** for each visit
o emergency room o surgery ***For the services billed by the doctor, you will pay an additional $15 or $30 depending on the type of doctor who treats you.***	**$150** for each visit
Mental Health and Substance Abuse Outpatient Services	
o office visits	**$15** per visit/PCP or **$30** for Specialist visits
o outpatient facility (including partial day treatment and intensive outpatient programs) o outpatient facility professional provider services	**$30** per facility visit plus $15 per PCP/$30 Specialist visit in an outpatient facility

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

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In-Network Services	You Pay
Care at Home	
o home health care visits by a nurse or aide (90 visits)	**20%** of the amount the health care professionals in our network have agreed to accept for their services
o hospice care	**No charge**
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
Inpatient Stays in a Network Hospital or Facility	
o semi-private room, intensive care or similar unit ***You do not have to pay another $300 if you are readmitted within 90 days of the day you went home.***	**$300 plus 20%** for each admission*
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) ***If your physician submits one bill for prenatal, delivery, and postnatal care, services are covered as maternity delivery services.***	**20%** 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 $400 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 $400 of the cost of your care ($800 total).
- If three or more people are covered under your plan, together you will pay the first $800 of the cost of your care. However, the most one family member will pay is $400.

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 $400 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 $2,000 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 $2,000 ($4,000 total).
- 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.

When not using network professionals

If you are the only one covered by your plan, you will pay $4,000 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 $4,000 ($8,000 total).
- If three or more people are covered under your plan, together you will pay $8,000. However, no family member will pay more than $4,000 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 15 Plus 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.

Anthem Blue Cross and Blue Shield 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 Anthem Blue Cross and Blue Shield 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.