Brief summary of benefits comparing BlueCare 200 Plan to KeyCare 10 PPO - Changes in Red

Covered Services	BlueCare 200 Plan (Anthem BCBS)	KeyCare 10 PPO Plan (Anthem BCBS)
Calendar Year Deductible (Ded.) (Individual/Family)	$200 Individual / $400 Family	In-Network: None
Your Maximum Out-of-Pocket Expense Limit Per Cal. Year	$1,000 Individual / $2,000 Family	In-Network: $1,500 Individual / $3,000 Family
Referrals to Specialists by PCPs	No	No
Physician Office Visits	20% coinsurance after meeting the calendar year deductible	PCP - $10 copay Specialist - $20 copay
Diagnostic Labs, X-rays, and Other Outpatient Diagnostic Tests	20% coinsurance after meeting the calendar year deductible	10% coinsurance
Advanced Diagnostic Services	20% coinsurance after meeting the calendar year deductible	10% coinsurance
Outpatient Surgery	20% coinsurance after meeting the calendar year deductible	$100 copay plus 10% coinsurance for facility $10 or $20 copay for services billed by the doctor
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): 20% coinsurance Diagnostic testing such as ultrasounds, non-stress tests, and other fetal monitor procedures: 20% coinsurance	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: 10% coinsurance
Urgent Care Center	20% coinsurance after meeting the calendar year deductible	$10 PCP copay/$20 Specialist copay at doctor's office (urgent care centers billed as PCP or Specialist based on contract with Anthem)
Emergency Room Visit	20% coinsurance after meeting the calendar year deductible	$150 copay plus 10% coinsurance for facility 10% coinsurance for ER physician services
Ambulance Travel	20% coinsurance after meeting the calendar year deductible	$100 per transport
Dialysis Treatments	20% coinsurance after meeting the calendar year deductible	10% coinsurance
Home Care Services	20% coinsurance after meeting the calendar year deductible 90 visits per calendar year maximum	10% coinsurance 100 visits per calendar year maximum
Prosthetic Devices	20% coinsurance after meeting the calendar year deductible	20% coinsurance
Durable Medical Equipment	20% coinsurance after meeting the calendar year deductible	20% coinsurance
Outpatient Physical, Speech, Occupational Therapy	20% coinsurance after meeting the calendar year deductible 30 visits combined per calendar year for physical and occupational therapy; 30 visits per calendar year for speech therapy	$20 plus 10% coinsurance 30 visits combined per calendar year for physical and occupational therapy; 30 visits per calendar year for speech therapy
Cardiac-Rehab. Therapy	20% coinsurance after meeting the calendar year deductible	10% coinsurance
Respiratory Therapy	20% coinsurance after meeting the calendar year deductible	10% coinsurance
Chemotherapy	20% coinsurance after meeting the calendar year deductible	10% coinsurance
Radiation Therapy	20% coinsurance after meeting the calendar year deductible	10% coinsurance
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	20% coinsurance after meeting the calendar year deductible	$200 plus 10% for room & board 10% coinsurance for physician, nursing and professional services including anesthesia, surgical, and maternity delivery services
Skilled Nursing Facility Stays	20% coinsurance after meeting the calendar year deductible Limit of 100 days per stay	10% coinsurance Limit of 100 days per stay
Outpatient Mental Health and Substance Abuse (MHSA)	20% coinsurance after meeting the calendar year deductible	Office Visit: $10 per visit Facility & Professional Provider Services: 10% coinsurance
Inpatient MHSA Services	20% coinsurance after meeting the calendar year deductible	$200 plus 10% for room & board 10% coinsurance for physician, nursing and professional services including anesthesia, surgical, and maternity delivery services
Chiropractic Services	20% coinsurance after meeting the calendar year deductible Limited to 30 visits per calendar year	$20 copay per visit Limited to 30 visits per calendar year
Routine Vision Services	Annual eye exam - $15 copay in network $30 allowance if you use non-network vision provider	Annual eye exam - $15 copay in network $30 allowance if you use non-network vision provider
RX Retail Copays: RX Mail Order Copays:	$8/$15/$30 $8/$30/$90	$8/$15/$30 $8/$30/$90