# Brief summary of benefits comparing KeyCare 15 Plus PPO to KeyCare 10 PPO - Changes in Red

| Covered Services | KeyCare 15 Plus PPO Plan (Anthem BCBS) | KeyCare 10 PPO Plan (Anthem BCBS) |
|---|---|---|
| Calendar Year Deductible (Ded.) (Individual/Family) | In-Network: None | In-Network: None |
| Your Maximum Out-of-Pocket Expense Limit Per Cal. Year | In-Network: $2,000 Individual / $4,000 Family | In-Network: $1,500 Individual / $3,000 Family |
| Referrals to Specialists by PCPs | No | No |
| Physician Office Visits | PCP - $15 copay<br>Specialist - $30 copay | PCP - $10 copay<br>Specialist - $20 copay |
| Diagnostic Labs, X-rays, and Other Outpatient Diagnostic Tests | $30 copay | 10% coinsurance |
| Advanced Diagnostic Services | $150 copay | 10% coinsurance |
| Outpatient Surgery | $150 copay for facility<br>$15 or $30 copay for services billed by the doctor | $100 copay plus 10% coinsurance for facility<br>$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) | If OB submits one bill for all services - 20% coinsurance<br>If OB bills separately for services - $30 per visit or test | Routine pre and postntal care (excluding inpatient stays): $150 copay per pregnancy<br>Diagnostic testing such as ultrasounds, non-stress tests, and other fetal monitor procedures: 10% coinsurance |
| Urgent Care Center | $15 PCP copay/$30 Specialist copay at doctor's office (urgent care centers billed as PCP or Specialist based on contract with Anthem) | $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 | $150 copay for facility<br>$30 copay for ER physician services | $150 copay plus 10% coinsurance for facility<br>10% coinsurance for ER physician services |
| Ambulance Travel | 20% coinsurance | $100 per transport |
| Dialysis Treatments | Covered in full | 10% coinsurance |
| Home Care Services | 20% coinsurance<br>90 visits per calendar year maximum | 10% coinsurance<br>100 visits per calendar year maximum |
| Prosthetic Devices | 20% coinsurance | 20% coinsurance |
| Durable Medical Equipment | 20% coinsurance | 20% coinsurance |
| Outpatient Physical, Speech, Occupational Therapy | $30 copay<br>30 visits combined per calendar year for physcial and occupational therapy;<br>30 visits per calendar year for speech therapy | $20 plus 10% coinsurance<br>30 visits combined per calendar year for physical and occupational therapy;<br>30 visits per calendar year for speech therapy |
| Cardiac-Rehab. Therapy | Covered in full | 10% coinsurance |
| Respiratory Therapy | Covered in full | 10% coinsurance |
| Chemotherapy | Covered in full | 10% coinsurance |
| Radiation Therapy | Covered in full | 10% coinsurance |
| Autism Spectrum Disorder (Children age 2 through 6) | Not covered | Diagnosis and Treatment - Cost share based on services rendered<br>Applied Behavioral Analysis - 20% to $35,000 limit per member per year |
| Inpatient Hospital Services | $300 plus 20% coinsurance | $200 plus 10% coinsurance |
| Skilled Nursing Facility Stays | 20% coinsurance; Limit of 100 days per stay | 10% coinsurance; Limit of 100 days per stay |
| Outpatient Mental Health and Substance Abuse (MHSA) | Office Visit: $15 copay<br>Facility & Professional Provider Services: $30 copay | Office Visit: $10 copay<br>Facility & Professional Provider Services: 10% coinsurance |
| Inpatient MHSA Services | $300 plus 20% coinsurance | $200 plus 10% coinsurance |
| Chiropractic Services | $30 copay per visit<br>Limited to 30 visits per calendar year | $20 copay per visit<br>Limited to 30 visits per calendar year |
| Routine Vision Services | Annual eye exam - $15 copay in network<br>Discounts on eye wear and laser vision correction surgery<br>$30 allowance if you use non-network vision provider | Annual eye exam - $15 copay in network<br>Discounts on eye wear and laser vision correction surgery<br>$30 allowance if you use non-network vision provider |
| RX Retail Copays:<br>Mail Order Copays: | $8/$15/$30<br>$8/$30/$90 | $8/$15/$30<br>$8/$30/$90 |
| Out-of-Network Benefits | Calendar Year Deductible: $400 / $800<br>Calendar Year Out-of-Pocket Limit: $4,000 / $8,000<br>Coinsurance: 30% Coinsurance | Calendar Year Deductible: $200 / $400<br>Calendar Year Out-of-Pocket Limit: $3,000 / $6,000<br>Coinsurance: 30% Coinsurance |