
Anthem Blue Cross Blue Shield Health Keycare 200 Open Access Plan (PPO)

Effective Date: October 1, 2009

Preferred Provider Organization (PPO) – The KeyCare PPO Plan provides a large network of providers and hospitals which members can access.

HEALTH INSURANCE	KEYCARE 200- In-Network
Out-of-Pocket Max	\$1,500 per individual; \$3,000 per family
Deductible	\$200 per individual \$400 per family
Physician Office Co-pay	\$15.00
Routine Wellness	\$0.00 1 visit per year per member
WELL BABY CARE (until the day the child turns 7)	100% of AC
Immunizations	100% of AC
INPATIENT SERVICES	
Inpatient Hospital	90% of AC* after deductible
Inpatient Provider/Doctor	90% of AC after deductible
Mental Health Inpatient	90% of AC after deductible

HEALTH INSURANCE	KEYCARE 200
Skilled Nursing Facility	90% of AC after deductible (100 days per confinement)
Pre-Hospital Admission	Call 1-800-242-7277
PROVIDER SERVICES	
Primary Care Physician	Not required
Referral for Specialist	Not required
OUTPATIENT EXPENSES	
Specialist Office Visit	100% of AC after \$15 copay
Diagnostic Testing	90% of AC after deductible
Advanced Diagnostic Imaging	90 % of AC after deductible
Facility/Surgery (OP)	90 % of AC after deductible
Mental Health	100% of AC after \$15 physician copay-no visit limit
ROUTINE WELLNESS	
Routine visits and screenings	100% of AC
Immunizations	100% of AC
Routine labs/x-rays	100% of AC
WELL WOMEN EXAM	
Routine GYN Exam (1/cy)	100% of AC

HEALTH INSURANCE	KEYCARE 200
Mammograms	100% of AC
Pap Smears	100% of AC
MATERNITY	
Pre & Post Natal Care Delivery	\$15 physician copay and Anthem pays 90% of global bill
Diagnostic Testing	90% of AC after deductible
EMERGENCIES	
Emergency Room, Accidents, Medical Emer- gencies	90% of AC after deductible
OTHER SERVICES	
Physical Therapy, or Occupational Therapy	90% of AC after deductible (\$2,000 maxi- mum/combined CY max for PT and OT)
Private Duty Nursing	90% of AC after deductible (\$500 max/C/Y)
Medical Equipment	90% of AC after deductible (\$5,000 max/ C/Y)
Ground Ambulance Services	90% of AC after deductible (\$3,000 max/C/Y)
Speech Therapy	90% of AC after deductible (\$500 max/C/Y)
ROUTINE VISION (Blue View Vision Network)	100% of AC after \$15 copay; (discounts on frames & lenses) \$30 out of network allowance
OUT-OF-NETWORK BENEFITS	Calendar Year Deductible- \$300/\$600 Coinsurance- 70% of AC after Ded. Out-of-Pocket Max.- \$2250/4500

PHARMACY BENEFITS

HEALTH INSURANCE	For KeyCare (employee pays)	
PRESCRIPTION DRUG	Up to 30-day Medication Supply	Up to 90-day Medication Supply
	<i>From Retail Pharmacy</i>	<i>Home Delivery Service</i>
Tier 1 Medications	\$10 copay	\$20 copay
Tier 2 Medications	\$20 copay	\$40 copay
Tier 3 Medications	\$35 or 20% of script cost (\$200 per script maximum)	\$70 or 20% of script cost (\$400 per script maximum)
Out-of-Pocket Maximum	\$3500 per member	

* AC- allowable charge

***Out-of-Pocket Maximum (Stop-Loss) - You and the plan share copayment responsibilities only up to the annual Out-of-Pocket Maximum. Beyond that limit, the plan covers 100% of allowable charges for covered services through the end of the calendar year. The annual Out-of-Pocket Limit for your plan is indicated above for each plan being offered. Please reference your handbook for expenses that apply toward the Out-of-Pocket Maximum.

Please be advised this is an illustrative summary for informational purposes only. The applicable Medical Plan Booklet will be distributed to all employees who enroll in the health care program. The aforementioned Medical Plan Booklet will provide a thorough description of your benefit plan.

Monthly Keycare 200 Rates

	Total Premium	County Portion	<u>Employee Portion</u>
Employee ONLY	\$642.33	\$322.00	\$321.17
Employee + 1 Child	\$836.31	\$322.00	\$515.14
Employee + Children	\$885.70	\$322.00	\$564.53
Employee + Spouse	\$1,112.53	\$322.00	\$791.36
FAMILY	\$1,265.30	\$322.00	\$944.13

For questions or claims please contact Customer Service at
1.804.358.1551 or 1.800.451.1527
Website: www.anthem.com

