## *Anthem KeyCare Expanded 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.<br><br>* 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<br>***Plus – valuable discounts on eyewear*** | **$25** for each visit |
| **Doctor Visits** | |
| o office visits<br>o home visits<br>o pre- and post- natal office visits<br>o in-office surgery<br>o urgent care visits<br>o spinal manipulations and other manual medical intervention visits (30 visit plan year maximum) | **$15 co-payment** for each visit to a family or general practitioner, internist, or pediatrician<br><br>**$25 co-payment** for each visit to a specialist |
| o mental health and substance abuse professional office visits | **$0** of the amount the health care professionals in our network have agreed to accept for their services |
| **Outpatient care** | |
| o diagnostic lab services<br>o diagnostic x-rays<br>o shots and therapeutic injections | **10%** of the amount the health care professionals in our network have agreed to accept for their services |
| **Outpatient Visits in a Hospital or Facility** | |
| o emergency room<br>o surgery<br>*Co-payment is waived if admitted. | **$100** for each facility visit*<br>**$15** for Primary Care Physician<br>**$25** for Specialist |
| **Inpatient Stays in a Network Hospital or Facility** | |
| o semi-private room, intensive care or similar unit<br>o physician, nursing and other medically necessary professional services in the hospital including anesthesia, surgical and maternity delivery services<br>o mental health and substance abuse partial-day treatment programs<br>* *Inpatient co-payment waived for Future Moms registrants. (Registrant must enroll during first trimester and complete full program)* | **$200** co-payment per inpatient stay* |
| o skilled nursing facility care (180 days per stay limit)<br>o home health care visits by a nurse or aide (90 visit plan year limit)<br>o hospice care | **$0** of the amount the health care professionals in our network have agreed to accept for their services |

***For benefits listed with specific limits all services received during the plan year from October 1 and September 30 for that benefit are applied to that limit (whether received in or out-of-network).***

| All Other In-Network Services | You Pay |
|---|---|
| You will pay all the costs associated with your care until you have paid $100 in one plan year. This is known as your deductible. **Your deductible amount begins anew on October 1 each year.**<br><br>o If two people are covered under your plan, each of you will pay the first $100 of the cost of your care ($200 total).<br>o If three or more people are covered under your plan, together you will pay the first $200 of the cost of your care. However, the most one family member will pay is $100.<br><br>**Once you reach your deductible you pay:** | |

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| **Autism Spectrum Disorder (ASD) – For children from age 2 through 6** | |
| o diagnosis and treatment of autism spectrum disorder including:<br>o behavioral health treatment*<br>o pharmacy care<br>o psychiatric care<br>o psychological care<br>o therapeutic care**<br>* ***Mental Health Services***<br>****Unlimited physical, occupational and speech therapy.*** | Member cost shares will be dependent on the services rendered. |
| o applied behavioral analysis<br>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*<br>****Unlimited physical, occupational and speech therapy*** | Member cost shares will be dependent on the services rendered. |
| **Outpatient Services** | |
| o professional ground ambulance services<br>o medical appliances, supplies and medications including infusion medications<br>o durable medical equipment<br>o private duty nursing (*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 charges.*) | **20%** of the amount the health care professionals in our network have agreed to accept for their services |
| **Labs, X-rays and Other Outpatient Services** | |
| o respiratory therapy<br>o infusion services<br>o dialysis<br>o radiation therapy<br>o chemotherapy (not given orally)<br>o physical and occupational therapy<br>o speech therapy visits | **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 plan year. This is called your out-of-network deductible.

- o If two people are covered under your plan, each of you will pay the first $200 of the cost of your care ($400 total).
- o 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 you will also pay an additional 25% 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 $50 (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 Plan Year**

**When using network professionals**

If you are the only one covered by your plan, you will pay $1,000 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.*

- o If two people are covered under your plan, each of you will pay $1,000 ($2,000 total).
- o If three or more people are covered under your plan, together you will pay $2,000. However, no family member will pay more than $1,000 toward the limit.

**When not 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.*

- o If two people are covered under your plan, each of you will pay $2,000 ($4,000 total).
- o 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.

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

- your share of the cost of 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 Expanded 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.*
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