

# Anthem KeyCare 30

In-Network Services	You Pay
<b>Preventive Care Services</b> 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.	<b>No charge</b>
<b>Routine Vision</b> o annual routine eye exam <i>Plus valuable discounts on eyewear</i>	<b>\$15</b> for each visit
<b>Doctor Visits</b> o office visits o urgent care visits o pre- and postnatal office visits* o home visits *If your physician submits one bill for prenatal, delivery, and postnatal care, services are covered as maternity delivery services. (See Inpatient stay section.) o mental health and substance abuse office visit	<b>\$30</b> for each visit to a PCP or specialist  <b>No charge</b>
All Other In-Network Services	You Pay
You will pay all the costs associated with care until you have paid \$1,000 in one calendar or plan year. This is known as your deductible.  o If two people are covered under your plan, each of you will pay the first \$1,000 of the cost of your care (\$2,000 total). o If three or more people are covered under your plan, together you will pay the first \$2,000 of the cost of your care. However, the most one family member will pay is \$1,000. <b>Once you reach your deductible you pay:</b> <b>Autism Spectrum Disorder (ASD) – For children from age 2 through 6</b> o diagnosis and treatment of autism spectrum disorder including: o behavioral health treatment*                      o pharmacy care o psychiatric care    o psychological care o therapeutic care** * <b>Mental Health Services</b> ** <b>Unlimited physical, occupational and speech therapy.</b>  o applied behavioral analysis o limited to a \$35,000 per member annual maximum	
<b>Early Intervention – For children from birth through age 2</b>  o unlimited per member per calendar year up to age 3	
<b>Other Outpatient Services</b> o shots and therapeutic injections o medical appliances, supplies and medications, including infusion medications o durable medical equipment o diagnostic lab services o in-office surgery o chemotherapy (not given orally), IV, radiation, cardiac and respiratory therapy o spinal manipulation and other manual medical intervention visits (30 visit limit)  o physical and occupational therapy visits in an office setting o speech therapy visits in an office setting o dialysis o diagnostic x-rays o ambulance travel	
	<b>20%</b> of the amount the health care professionals in our network have agreed to accept for their services
	Member cost shares will be dependent on the services rendered.
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Your benefit period is calendar year. A calendar year means your benefit period runs from January through December.

**For benefits listed with specific limits all services received in the calendar year or plan year for that benefit are applied to that limit (whether received in or out-of-network).**

Option 3.3/12

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In-Network Services	You Pay
<b>Other Outpatient Services - Continued</b>	
<ul style="list-style-type: none"> <li>o diabetic supplies, equipment and education</li> </ul>	Member cost shares will be dependent on the services rendered.
<b>Outpatient Services in a Hospital or Facility</b>	
<ul style="list-style-type: none"> <li>o physical therapy and occupational therapy</li> <li>o speech therapy</li> <li>o partial day mental health and substance abuse services</li> <li>o emergency room</li> <li>o surgery</li> </ul>	20% of the amount the health care professionals in our network have agreed to accept for their services
<b>Care at Home</b>	
<ul style="list-style-type: none"> <li>o home health care</li> <li>o private duty nursing limited to 16 hours per member per calendar year*</li> </ul> <p>*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.</p>	20% of the amount the health care professionals in our network have agreed to accept for their services
<b>Inpatient Stays in a Network Hospital or Facility</b>	
<ul style="list-style-type: none"> <li>o semi-private room, intensive care or similar unit</li> <li>o physician, nursing and other medically necessary professional services in the hospital including anesthesia, surgical and maternity delivery services.</li> <li>o skilled nursing facility care (100 days for each admission)</li> </ul>	20% of the amount the health care professionals in our network have agreed to accept for their services
<b>Out-of-Network Services</b>	
<b>Using Doctors, Hospitals and Other Health Care Professionals not Contracted to Provide Benefits</b>	
<p>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 \$1,500 in one calendar year. This is called your out-of-network deductible.</p> <ul style="list-style-type: none"> <li>o If two people are covered under your plan, each of you will pay the first \$1,500 of the cost of your care (\$3,000 total).</li> <li>o If three or more people are covered under your plan, together you will pay the first \$3,000 of the cost of your care. However, the most one family member will pay is \$1,500.</li> </ul> <p>Once you have reached this amount, when you receive covered services we will pay 60% 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 \$1,500 out-of-network deductible) and you will pay the rest of what the professional charges.</p>	
<b>Out-of-Pocket Maximums</b>	
<b>What You Will Pay for Covered Services in One Calendar or Plan Year</b>	
<p><b>When using network professionals</b></p> <p>If you are the only one covered by your plan, you will pay \$3,000 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.*</p> <ul style="list-style-type: none"> <li>o If two people are covered under your plan, each of you will pay \$3,000 (\$6,000 total).</li> <li>o If three or more people are covered under your plan, together you will pay \$6,000. However, no family member will pay more than \$3,000 toward the limit.</li> </ul> <p><b>When not using network professionals</b></p> <p>If you are the only one covered by your plan, you will pay \$4,500 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.*</p> <ul style="list-style-type: none"> <li>o If two people are covered under your plan, each of you will pay \$4,500 (\$9,000 total).</li> <li>o If three or more people are covered under your plan, together you will pay \$9,000. However, no family member will pay more than \$4,500 toward the limit.</li> </ul> <p>*The following do not count toward the calendar or plan year out-of-pocket maximum:</p> <ul style="list-style-type: none"> <li>o the cost of care received when the benefit limits have been reached</li> <li>o the cost of services and supplies not covered under your Anthem KeyCare 30 plan</li> <li>o the additional amount health care professionals not in our network may bill you when their charge is more than what we pay</li> </ul>	

*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.  
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