Your Anthem Benefits

Anthem

Anthem KeyCare 25

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. * 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 ***Plus valuable discounts on eyewear***	**$15** for each visit
Doctor Visits	
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.)***	**$25** for each visit to a PCP **$50** for each visit to a specialist
o mental health and substance use visits	**$25** for each visit
o spinal manipulations and other manual medical intervention visit (30 visit limit)	**$25** for each visit
All Other In-Network Services	**You Pay**
You will pay all the costs associated with care until you have paid $500 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 $500 of the cost of your care ($1,000 total). o If three or more people are covered under your plan, together you will pay the first $1,000 of the cost of your care. However, the most one family member will pay is $500. **Once you reach your deductible you pay:**	
Autism Spectrum Disorder (ASD) – For children from age 2 through 6	
o diagnosis and treatment of autism spectrum disorder including: o behavioral health treatment* o psychiatric care o therapeutic care** o pharmacy care o psychological care * ***Mental Health Services*** ****Unlimited physical, occupational and speech therapy.***	Member cost shares will be dependent on the services rendered.
o applied behavioral analysis o unlimited 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 up to age 3	
o unlimited per member per calendar year up to age 3	Member cost shares will be dependent on the services rendered.
Other Outpatient Services	
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 ***Limit does not apply to Autism Spectrum Disorder.*** o physical and occupational therapy visits in an office setting (30 combined visits)* o speech therapy visits in an office setting (30 visit limit)* o dialysis o diagnostic x-rays o ambulance travel	**20%** of the amount the health care professionals in our network have agreed to accept for their services

Your benefit period may be a calendar year or a plan year. A calendar year means your benefit period runs from January through December while a plan year runs from the effective date of the plan through a 12-month period (e.g. February 1 through January 31 or July 1 through June 30). Check with your employer to learn whether your benefits will be calculated on a calendar year or plan year basis.

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).

01/15 ASO

In-Network Services	You Pay
Other Outpatient Services - Continued	
o diabetic supplies, equipment and education	Member cost shares will be dependent on the services rendered.
Outpatient Visits in a Hospital or Facility	
o physical therapy and occupational therapy (30 combined visits)* o speech therapy (30 visit limit)* o partial day mental health and substance use services o emergency room o surgery ***Limit does not apply to Autism Spectrum Disorder.***	**20%** of the amount the health care professionals in our network have agreed to accept for their services
Care at Home	
o home health care (100 visits) o private duty nursing limited to 16 hours per member per calendar year ***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.***	**20%** of the amount the health care professionals in our network have agreed to accept for their services
o hospice care	**No charge**
Inpatient Stays in a Network Hospital or Facility	
o semi-private room, intensive care or similar unit o physician, nursing and other medically necessary professional services in the hospital including anesthesia, surgical and maternity delivery services. o skilled nursing facility care (100 days for each admission)	**20%** 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 $750 in one calendar or plan year. This is called your out-of-network deductible.

- If two people are covered under your plan, each of you will pay the first $750 of the cost of your care ($1,500 total).
- If three or more people are covered under your plan, together you will pay the first $1,500 of the cost of your care. However, the most one family member will pay is $750.

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 $750 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 Calendar or plan Year

When using network professionals

If you are the only one covered by your plan, you will pay $2,500 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.*

- If two people are covered under your plan, each of you will pay $2,500 ($5,000 total).
- If three or more people are covered under your plan, together you will pay $5,000. However, no family member will pay more than $2,500 toward the limit.

When not using network professionals

If you are the only one covered by your plan, you will pay $3,750 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.*

- If two people are covered under your plan, each of you will pay $3,750 ($7500 total).
- If three or more people are covered under your plan, together you will pay $7500. However, no family member will pay more than $3750 toward the limit.

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

- your share of the cost of adult 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 benefits
- 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.

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.