

Anthem KeyCare 30 Plan

In-Network Services	You Pay
Preventive Care Services	
<ul style="list-style-type: none"> ○ checkups ○ gynecological exams ○ prostate exams 	<p>\$30 for each visit to a PCP \$60 for each visit to a specialist</p>
<ul style="list-style-type: none"> ○ well-baby visits 	<p>\$30 for each visit to a PCP \$60 for each visit to a specialist</p>
<ul style="list-style-type: none"> ○ Pap tests ○ immunizations ○ mammograms ○ Prostate Specific Antigen (PSA) tests ○ screening tests 	<p>20% of the amount the health care professionals in our network have agreed to accept for their services</p>
Routine Vision	
<ul style="list-style-type: none"> ○ annual routine eye exam <p><i>Plus valuable discounts on eyewear</i></p>	<p>\$15 for each visit</p>
Doctor Visits	
<ul style="list-style-type: none"> ○ office visits ○ urgent care visits ○ home visits ○ pre- and postnatal office visits* ○ mental health and substance abuse visits <p><i>*If your physician submits one bill for prenatal, delivery, and postnatal care, services are covered as maternity delivery services. (See Inpatient stay section.)</i></p>	<p>\$30 for each visit to a health care provider \$60 for each visit to a specialist</p>
All Other In-Network Services	
<p>You will pay all the costs associated with care until you have paid \$1,000 in one calendar year. This is known as your deductible.</p> <ul style="list-style-type: none"> ○ 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). ○ 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. <p>Once you reach your deductible you pay:</p>	
Other Outpatient Services	
<ul style="list-style-type: none"> ○ shots and therapeutic injections ○ medical appliances, supplies and medications, including infusion medications ○ durable medical equipment (\$5,000 maximum) ○ dialysis ○ lab services ○ x-rays ○ professional ground ambulance services (\$3,000 maximum) ○ physical and occupational therapy visits in an office setting (combined \$2,000 maximum) ○ speech therapy visits in an office setting (\$500 maximum) ○ spinal manipulation and other manual medical intervention visits (\$500 maximum) ○ chemotherapy, IV radiation and respiratory therapy ○ in-office surgery 	<p>20% of the amount the health care professionals in our network have agreed to accept for their services</p>
Outpatient Visits in a Hospital or Facility	
<ul style="list-style-type: none"> ○ physical therapy and occupational therapy (combined \$2,000 maximum) ○ speech therapy (\$500 maximum) ○ emergency room ○ surgery 	<p>20% of the amount the health care professionals in our network have agreed to accept for their services</p>

For benefits listed with specific limits all services received during the calendar year from January 1 to December 31 for that benefit are applied to that limit (whether received in or out-of-network). Your deductible amount begins anew on January 1 each year. Any amount you pay toward your deductible during the 4th quarter of each calendar year—October, November, December—will apply not only to your deductible for that year but will also apply to your deductible for the following year.

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In-Network Services	You Pay
Care at Home	
<ul style="list-style-type: none"> home health care visits by a nurse or aide (90 visits) hospice care private duty nursing (\$500 maximum)* <i>*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.</i> 	20% of the amount the health care professionals in our network have agreed to accept for their services
Inpatient Stays in a Network Hospital or Facility	
<ul style="list-style-type: none"> semi-private room, intensive care or similar unit physician, nursing and other medically necessary professional services in the hospital including anesthesia, surgical and maternity delivery services. skilled nursing facility care (100 days for each admission) mental health and substance abuse partial-day treatment programs 	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
<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"> 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). 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. <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>

Out-of-Pocket Maximums
What You Will Pay for Covered Services in One Calendar Year (January 1 - December 31)
<p>When using network professionals 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"> If two people are covered under your plan, each of you will pay \$3,000 (\$6,000 total). 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. <p>When not using network professionals 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"> If two people are covered under your plan, each of you will pay \$4,500 (\$9,000 total). 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. <p>*The following do not count toward the calendar year out-of-pocket maximum:</p> <ul style="list-style-type: none"> your share of the cost of prescription drugs and 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 30 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.*