Your Anthem Benefits

Anthem

PPO Plan 4

January 1, 2018 – December 31, 2018

This Schedule provides just a summary of the Covered Expenses, Limitations and Exclusions under the Plan. All benefits below are subject to the Plan's terms and conditions, including Deductibles, Coinsurance, In Network discounts and Allowable Charges, as set forth in the Plan Document to which this Schedule is attached. Please read this Schedule only in conjunction with the Plan Document.

Benefits payable by the Plan may change depending upon whether Covered Services are obtained from a Participating Provider. The list of Participating Providers may change from time to time. A list of Participating Providers is located at www.anthem.com. Therefore, it is important to verify that the Provider who is treating you is currently a Participating Provider.

DEDUCTIBLE DOES NOT APPLY FOR SERVICES WHERE THERE IS A FLAT COPAY

In-Network Services (Not subject to calendar year deductible)	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***
Doctor Visits	
o office visits o urgent care visits o home visits o pre- and postnatal office visits o spinal manipulations and other manual medical intervention visits (30 visit limit per CY) o in-office surgery o speech therapy visits in an office setting (30 visit limit per CY) o diagnostic lab and x-ray services performed in a physician's office o early intervention o allergy testing	**$20** for each visit to a family or general practitioner, internist or pediatrician **$40** for each visit to a specialist
o online visits (https://livehealthonline.com) (does not include livehealthonline mental health/substance abuse therapist visits)	**$10** for each visit
o physical and occupational therapy in an office setting (combined 30 visit limit per CY)	**$30** for each visit to a specialist
o mental health conditions and substance use disorder visits (including LHO therapist visits)	**$20** for each visit
o allergy shots/serum ***If services are billed with an office visit charge, the office visit copay will apply***	**No Charge***
Routine Vision	
o annual routine eye exam ***Plus — valuable discounts on eyewear***	**$15** for each visit

All Other In-Network Services	You Pay
You will pay all the costs associated with your care until you have paid $500 in one calendar 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. o The deductible is included in the out-of-pocket maximum. **Once you reach your deductible you pay:** **(DEDUCTIBLE DOES NOT APPLY TO FLAT COPAY SERVICES)**	
Maternity Services	
o initial visit to confirm pregnancy and all routine pre- and postnatal office visits (excluding inpatient stays)	One time copay of **$20** to PCP or **$40** to a specialist (deductible does not apply)
o diagnostic testing (such as ultrasounds, non-stress tests and other fetal monitor procedures)	**20%** of the amount the health care professionals in our network have agreed to accept for their services
Autism Spectrum Disorder (ASD)	
○ Behavioral Health Treatment: mental health services	**Office Visit: $20** for each visit (deductible does not apply) **Outpatient Facility: 0%** (after meeting deductible) **Inpatient Facility: 20%** (after meeting deductible)
○ Pharmacy Care	**Office Visit: $20** for each visit (deductible does not apply)
○ Psychiatric Care	**Office Visit: $20** for each visit (deductible does not apply) **Outpatient Facility: 0%** (after meeting deductible) **Inpatient Facility: 20%** (after meeting deductible)
○ Psychological Care	**Office Visit: $20** for each visit (deductible does not apply) **Outpatient Facility: 0%** (after meeting deductible) **Inpatient Facility: 20%** (after meeting deductible)
○ Therapeutic Care: unlimited physical, occupational and speech therapy	**Office Visit: $20** for each visit to a family or general practitioner, internist or pediatrician; **$40** for each visit to a specialist (deductible does not apply) **Outpatient Facility: $40** for each visit to a specialist (deductible does not apply)
○ Applied Behavioral Analysis	**No charge** (deductible does not apply)
Labs, X-rays and Other Outpatient Services	
o respiratory therapy o shots and therapeutic injections (other than allergy shots) o dialysis o chemotherapy (not given orally) o diagnostic lab and x-ray services performed outside a physician's office o medical appliances, supplies and medications, including infusion medications o complex diagnostic imaging (requires pre-authorization) o professional ground ambulance services o durable medical equipment o radiation therapy	**20%** of the amount the health care professionals in our network have agreed to accept for their services

In-Network Services	You Pay
Outpatient Visits in a Hospital or Facility	
o emergency room o surgery o physician services	**20%** of the amount the health care professionals in our network have agreed to accept for their services
o physical therapy and occupational therapy (combined 30 visit limit per CY)	**$30** per visit to a specialist (deductible does not apply)
o speech therapy (30 visit limit per CY)	**$20** per visit to your PCP **$40** per visit to a specialist (deductible does not apply)
o mental health conditions and substance use disorder	**0%** of the amount the health care professionals in our network have agreed to accept for their services
Care at Home	
o home health care visits by a nurse or aide (90 visits) o hospice care o private duty nursing (16 hours per member per year)	**No charge** (deductible does not apply)
Inpatient Stays in a Network Hospital or Facility	
o semi-private room, intensive care or similar unit (includes inpatient mental health/substance abuse admission and maternity admissions; requires pre-authorization) 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 and requires pre-authorization) o mental health conditions and substance use disorders partial-day treatment programs	**20%** 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 calendar year from January 1 and 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.

The outpatient pharmacy benefit is administered separately by MedImpact. See separate MedImpact materials for more information. Out of Pocket Outpatient prescription drug cost shares do not count towards the Medical Out-of-pocket maximum listed on the next page.

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 $500 in one calendar 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 $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. o The out-of-network deductible is not combined with the in-network deductible. Once you have reached this amount, when you receive covered services we will pay 70% 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 $500 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 Year (January 1 - December 31)

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.*

- 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.

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.*

- 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.
- The out-of-network out-of-pocket maximum is not combined with the in-network out-of-pocket maximum.

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

- 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 PPO 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.