Anthem

PPO Plan 6

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.

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 cost share***
Routine Vision	
○ annual routine eye exam ***Plus — valuable discounts on eyewear*** 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 your deductible) and you will pay the rest of what the provider charges.	**$15** copay for each visit (deductible does not apply)

Annual Deductible

Your deductible is combined for In-network and Out-of-Network services.

- For single coverage, you will pay all the costs associated with your care until you have paid $1,500 in one calendar year.
- If two or more people are covered under your plan, together you will pay the first $3,000 of the cost of care in one calendar year.

In-Network Services

Once you and your covered family members have reached your deductible, you will pay the amounts designed below in the "you pay" column.

Out-of-Network Services

For covered services to out-of-network providers, you will pay 30%. However, 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.

Once you reach your deductible, you will pay the following for covered in-network services

All Other In-Network Services	You Pay
Doctor Visits	
○ office visits ○ urgent care visits ○ home visits ○ pre- and postnatal office visits ○ mental health and substance use visits ○ in-office surgery ○ online visits (https://livehealthonline.com) ○ physical and occupational therapy in an office setting (30 combined visits)* ○ speech therapy visits in an office setting (30 visit limit)* ○ spinal manipulations and other manual medical intervention visits (30 visit limit) **** 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
Labs, Diagnostic X-rays and Other Outpatient Services	
○ diagnostic lab services ○ shots and therapeutic injections ○ medical appliances, supplies and medications, including infusion medications ○ diagnostic x-rays ○ dialysis ○ ambulance travel ○ durable medical equipment ○ chemotherapy (not given orally), radiation, cardiac and respiratory therapy	**20%** of the amount the health care professionals in our network have agreed to accept for their services
○ diabetic supplies, equipment and education	**20%** of the amount the health care professionals in our network have agreed to accept for their services

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Autism Spectrum Disorder (ASD)	
o diagnosis and treatment of autism spectrum disorder including: o behavioral health treatment* o pharmacy care (office or facility setting) o psychiatric care o psychological care o therapeutic care** ***Mental Health Services*** ****Unlimited physical, occupational and speech therapy.***	**20%** of the amount the health care professionals in our network have agreed to accept for their services
o applied behavioral analysis	**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	**20%** 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 physical therapy and occupational therapy (30 combined visits)* o speech therapy (30 visit limit)* o surgery o emergency room o physician services o mental health and substance use partial-day treatment programs ***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 is 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
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

Your benefit period is a 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).

The outpatient pharmacy benefit is administered separately by MedImpact. See separate MedImpact materials for more information. Out of Pocket Outpatient prescription drug cost shares count towards the Medical Out-of-pocket maximum listed on the next page.

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Out-of-Pocket Maximums

What You Will Pay for Covered Services in One Calendar Year

When using network professionals

For single coverage, 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; together you will pay $6,000. 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.

When not using network professionals

For single coverage, you will pay $4,000 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; together you will pay $8,000. 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.

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.

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