Anthem HealthKeepers Value Advantage 25/500 Option 1 (2-50 Employees) A Point of Service Open Access plan

In-Plan 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 home visits o pre- and postnatal office visits* o urgent care 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 your PCP **$50** for each visit to a specialist
o mental health and substance abuse visits	**$25** for each visit
Spinal Manipulation	
o spinal manipulations and manual medical therapy services ***(Limited up to 30 visits per calendar or plan year)***	**$25** for each visit

All Other In-Plan Services	
You will pay all the costs associated with your 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:**	
Early Intervention – For children from birth through age 2	
o limited to a $5,000 per member annual maximum* ****Unlimited physical, occupational and speech therapy***	Member cost shares will be dependent on the services rendered.
Other Outpatient Services	
o ambulance travel o dialysis o in-office surgery o medical appliances, supplies and medications, including infusion medications o physical and occupational therapy visits in an office setting (30 combined visits)** o chemotherapy, IV, radiation, cardiac and respiratory therapy o durable medical equipment o lab services* o mental health and substance abuse partial-day treatment programs o speech therapy visits in an office setting (30 visit limit)** o shots and therapeutic injections o x-rays ****Other than outpatient lab and pathology services/tests performed by an HMO laboratory provider*** *****Limit does not apply to Early Intervention.***	**20%** of the amount the health care professionals in our plan have agreed to accept for their services
o diabetic supplies, equipment and education	Member cost shares will be dependent on the services rendered.

SPECIALIST VISITS DO NOT REQUIRE PCP REFERRAL.

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-plan).

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In-Plan Services	You Pay
Emergency Care and Out of the Service Area Urgent Care	
o urgent care visits	**$25** for each visit to your PCP **$50** for each visit to a specialist
o true emergency care visits in or out of the service area	**20%** of the amount health care professionals in our plan have agreed to accept for their services
Outpatient Visits in a Hospital or Facility	
o physical therapy and occupational therapy (30 combined visits per calendar or plan year)* o speech therapy (30 visits per calendar or plan year)* o surgery ***Limit does not apply to Early Intervention.***	**20%** of the amount the health care professionals in our plan have agreed to accept for their services
Care at home	
o home health care (100 visits) o private duty nursing	**20%** of the amount the health care professionals in our plan have agreed to accept for their services
o hospice care	**No charge**
Inpatient Stays in a Plan 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 per each admission)	**20%** of the amount the health care professionals in our plan have agreed to accept for their services

Out-of-Plan Services

It's important to remember that health care professionals not in our plan can charge whatever they want for their services. If what they charge is more than the fee our plan 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-plan 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 70% of the fee our plan health care professionals have agreed to accept for the same service. You will pay the rest, including any difference between the fee our plan health care professionals have agreed to accept for the same service and the amount the health care professional not in our plan charges. If you go to an eye care professional not in our plan for your routine eye examination, we will pay $30 (whether or not you have reached the $750 out-of-plan 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 in-plan 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 using out-of-plan 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 following do not count toward the calendar or plan 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 Anthem HealthKeepers Value Advantage 25/500 plan
- the additional amount health care professionals not in our plan may bill you when their charge is more than what we pay

Some benefits may be subject to balance billing, if provided by a non-participating provider. For more information on balance billing, see the enrollment brochure.
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.