### Important Questions | Answers | Why this Matters:

**What is the overall deductible?**

| | $5000 single/$10000 family for In Plan Provider. $7000 single /$14000 family for Out-of-Plan Provider. Does not apply to Prescription Drugs, In-Plan Preventive Care, Copayments, Hospice, Manipulative Services, Office Based Lab and Routine Eye Exam. In-Plan Provider and Out-of-Plan Provider deductibles are separate and do not count towards each other. |
|---|---|---|
| You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |

**Are there other deductibles for specific services?**

| No. |
| You don’t have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |

**Is there an out–of–pocket limit on my expenses?**

| Yes; In-Plan Provider Single: $8500 Family: $17000 Out-of-Plan Provider Single: $9500, Family: $19000 |
| The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |

**What is not included in the out–of–pocket limit?**

| Balance-Billed Charges, Pre-Authorization Penalties, Infertility Treatment Copays, Health Care This Plan Doesn’t Cover, Premiums, Costs for |
| Even though you pay these expenses, they don’t count toward the **out-of-pocket limit**. |

**Questions:** Call 1-855-333-5735 or visit us at [www.anthem.com](http://www.anthem.com).

If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.anthem.com](http://www.anthem.com) or call 1-855-333-5735 to request a copy.
**HealthKeepers**

**Anthem HealthKeepers Value Advantage 30/5000 POS Open Access**  
Coverage Period: 11/01/2013 - 10/31/2014

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs  
Coverage for: Individual/Family | Plan Type: POS

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Is there an overall annual limit on what the plan pays?</strong></td>
<td>No. This policy has no overall annual limit on the amount it will pay each year. The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.</td>
</tr>
<tr>
<td><strong>Does this plan use a network of providers?</strong></td>
<td>Yes. See <a href="http://www.anthem.com">www.anthem.com</a> or call 1-855-333-5735 for a list of participating providers. If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.</td>
</tr>
<tr>
<td><strong>Do I need a referral to see a specialist?</strong></td>
<td>No. You don’t need a referral to see a specialist. You can see the specialist you choose without permission from this plan.</td>
</tr>
<tr>
<td><strong>Are there services this plan doesn’t cover?</strong></td>
<td>Yes. Some of the services this plan doesn’t cover are listed on page 8. See your policy or plan document for additional information about excluded services.</td>
</tr>
</tbody>
</table>

**Important Terms:**

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan’s **allowed amount** for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven’t met your deductible.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use In Plan Provider by charging you lower deductibles, copayments and coinsurance amounts.

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## Summary of Benefits and Coverage: What this Plan Covers & What it Costs

**Plan Type:** POS

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Participating Provider</th>
<th>Your Cost If You Use a Non-Participating Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>$30 copay</td>
<td>30% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$50 copay</td>
<td>30% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td><strong>Manipulative Therapy</strong>&lt;br&gt;$25 copay</td>
<td><strong>Manipulative Therapy</strong>&lt;br&gt;30% coinsurance</td>
<td><strong>Manipulative Therapy</strong>&lt;br&gt;Coverage is limited to 30 visits per member per year. Failure to obtain preauthorization may result in non-coverage or reduced coverage. Services must be received by provider that participates in the American Specialty Health Network (ASHN).</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No cost share</td>
<td>30% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td><strong>Lab - Office</strong>&lt;br&gt;20% coinsurance</td>
<td><strong>Lab - Office</strong>&lt;br&gt;30% coinsurance</td>
<td><strong>Lab – Office</strong>&lt;br&gt;Copay does not apply when services are provided by the same provider on the same day as the office visit. Specialist copay must apply.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
<td>Failure to obtain preauthorization may result in non-coverage or reduced coverage.</td>
</tr>
</tbody>
</table>

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## Summary of Benefits and Coverage: What this Plan Covers & What it Costs

**Coverage for:** Individual/Family  |  **Plan Type:** POS

### Common Medical Event

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<tr>
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<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 – Typically Generic</td>
<td>$15 copay/prescription (retail and mail order)</td>
<td>$15 copay/prescription (retail only)</td>
<td>Covers up to a 30 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)</td>
</tr>
<tr>
<td>Tier 2 – Typically Preferred/Formulary Brand</td>
<td>$40 copay/prescription (retail only) and $80 copay/prescription (mail order only)</td>
<td>$40 copay/prescription (retail only) Balance billing may apply.</td>
<td>If a member selects a brand drug when a generic equivalent is available the member is responsible for the generic copay plus the cost difference between the generic and brand equivalent even if the physician indicates no substitutions. Covers up to a 30 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)</td>
</tr>
<tr>
<td>Tier 3 – Typically Non-preferred/Non-formulary and Specialty Drugs</td>
<td>$75 copay/script for retail. $225 copay/script for mail order.</td>
<td>$75 copay/script for retail. Balance billing may apply.</td>
<td>If a member selects a brand drug when a generic equivalent is available the member is responsible for the generic copay plus the cost difference between the generic and brand equivalent even if the physician indicates no substitutions. Covers up to a 30 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)</td>
</tr>
<tr>
<td>Specialty Drugs</td>
<td>Must be filled through mail order</td>
<td>Not covered</td>
<td>$3500 annual out-of-pocket limit for all covered drugs including specialty drugs per member per benefit year.</td>
</tr>
</tbody>
</table>

### If you need drugs to treat your illness or condition

More information about [prescription drug coverage](http://www.anthem.com/pHarmacyInformation/) is available at [www.anthem.com/pHarmacyInformation/](http://www.anthem.com/pHarmacyInformation/).

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</tr>
</thead>
<tbody>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>No coverage for non emergency use of emergency room.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$30 PCP/$50 Specialist</td>
<td>30% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
<td>Failure to obtain preauthorization may result in non-coverage or reduced coverage.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
<td>none</td>
</tr>
</tbody>
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### HealthKeepers

**Anthem HealthKeepers Value Advantage 30/5000 POS Open Access**  
Coverage Period: 11/01/2013 - 10/31/2014

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs  
**Coverage for:** Individual/Family | **Plan Type:** POS

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</thead>
</table>
| If you have mental health, behavioral health, or substance abuse needs               | Mental/Behavioral health outpatient services        | **Mental/Behavioral Health Office Visit**  
$30 copay  
**Mental/Behavioral Health Facility Visit – Facility Charges**  
20% coinsurance | **Mental/Behavioral Health Office Visit**  
30% coinsurance  
**Mental/Behavioral Health Facility Visit – Facility Charges**  
30% coinsurance |  
None |
|                                                                                     | Mental/Behavioral health inpatient services         | 20% coinsurance                                                 | 30% coinsurance                                                   |  
None |
|                                                                                     | Substance use disorder outpatient services          | **Substance Abuse Office Visit**  
$30 copay  
**Substance Abuse Facility Visit – Facility Charges**  
20% coinsurance | **Substance Abuse Office Visit**  
30% coinsurance  
**Substance Abuse Facility Visit – Facility Charges**  
30% coinsurance | **Substance Abuse Facility Visit – Facility Charges**  
Other outpatient services includes partial day. |
|                                                                                     | Substance use disorder inpatient services           | 20% coinsurance                                                 | 30% coinsurance                                                   |  
None |
| If you are pregnant                                                                 | Prenatal and postnatal care                         | 20% coinsurance                                                 | 30% coinsurance                                                   | Your doctor’s charges for delivery are a part of prenatal and postnatal care. |
|                                                                                     | Delivery and all inpatient services                 | 20% coinsurance                                                 | 30% coinsurance                                                   | Failure to obtain pre-authorization may result in non coverage or reduced benefits. |

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## Summary of Benefits and Coverage:

**HealthKeepers**

**Anthem HealthKeepers Value Advantage 30/5000 POS Open Access**

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<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
<td>Coverage is limited to 100 visits per year.</td>
</tr>
<tr>
<td></td>
<td>Home health care</td>
<td></td>
<td></td>
<td>Coverage is limited to 30 visits per year for physical therapy and occupational therapy combined, 30 visits per year for speech therapy. Limit does not apply to autism services, if applicable. Services form In-Plan Provider and Out-of-Provider count towards your limit.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
<td>Coverage is limited to 100 days per stay. Services form In-Plan Provider and Out-of-Provider count towards your limit.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
<td>——none— ——none—</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
<td>——none— ——none—</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
<td>——none— ——none—</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>No cost share</td>
<td>30% coinsurance</td>
<td>——none— ——none—</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Eye exam</td>
<td>$15 copay</td>
<td>All Costs less $30 allowance</td>
<td>One per calendar year. Deductible does not apply.</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Discounts are provided.</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>——none— ——none—</td>
</tr>
</tbody>
</table>

### Questions:

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Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Does NOT Cover (This isn’t a complete list. Check your policy or plan document for other excluded services.)</th>
</tr>
</thead>
</table>
| • Acupuncture  
• Bariatric surgery  
• Cosmetic surgery  
• Dental care (Adult)  
• Hearing aids  
• Infertility treatment  
• Long-term care  
• Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide  
• Private-duty nursing  
• Routine foot care Unless you have been diagnosed with diabetes. Consult your formal contract of coverage  
• Weight Loss programs |

<table>
<thead>
<tr>
<th>Other Covered Services (This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)</th>
</tr>
</thead>
</table>
| • Chiropractic care  
• Routine eye care (Adult) Coverage is limited to 1 screening exam. Consult your formal contract of coverage. |
Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-333-5735. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact:

Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform
P.O. Box 1157
Richmond, VA 23218
Telephone: Toll-Free (877) 310-6560
E-Mail: Ombudsman@scc.virginia.gov
Office of the Managed Care Ombudsman
Bureau of Insurance

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Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a’ tah ní’liigoo eí dooda’i, shikáa adoolwol iunizimigo t’áá diné k’ejiigo, t’áá shoodi ba na’ałníí ya sidáhi bich’i naabidiílkiid. Eí doo bigha daago ni ba’ni’ja’go ho’aalagi bich’i hodílní. Hái’dáa iini’taago eíya, t’áá shoodi diné ya atäh halne’ígii ni bées bée hane’i wólt’ bdí’ki s’inílíí bí’ké’go bich’i hodílní.

—To see examples of how this plan might cover costs for a sample medical situation, see the next page.—
About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

### Having a baby (normal delivery)
- **Amount owed to providers:** $7,540
- **Plan pays:** $1,920
- **Patient pays:** $5,620

**Sample care costs:**
- Hospital charges (mother) $2,700
- Routine obstetric care $2,100
- Hospital charges (baby) $900
- Anesthesia $900
- Laboratory tests $500
- Prescriptions $200
- Radiology $200
- Vaccines, other preventive $40

**Total** $7,540

**Patient pays:**
- Deductibles $5,000
- Copays $20
- Coinsurance $450
- Limits or exclusions $150

**Total** $5,620

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)
- **Amount owed to providers:** $5,400
- **Plan pays:** $250
- **Patient pays:** $5,150

**Sample care costs:**
- Prescriptions $2,900
- Medical Equipment and Supplies $1,300
- Office Visits and Procedures $700
- Education $300
- Laboratory tests $100
- Vaccines, other preventive $100

**Total** $5,400

**Patient pays:**
- Deductibles $5,000
- Copays $40
- Coinsurance $30
- Limits or exclusions $80

**Total** $5,150

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.anthem.com or 1-855-333-5735.

Questions: Call 1-855-333-5735 or visit us at www.anthem.com.

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don’t include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.
- The patient’s condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ No. Coverage Examples are not cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✔ Yes. When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✔ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you’ll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.