Your Anthem Benefits

Anthem

Washington and Lee University-Anthem KeyCare PPO Plan Year 7/1/2015

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 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 speech therapy (unlimited visits) o spinal manipulation and manual medical therapy services (30 visit limit) o in-office surgery o voluntary family planning o urgent care visits	**$15** for each visit to a PCP **$40** for each visit to a specialist
o physical and occupational therapy (unlimited visits)	**$40 for each visit**
o mental health and substance abuse visits	**$15 for each visit**
Labs, Diagnostic X-rays and Other Outpatient Services	
o diagnostic tests other than x-rays o lab work o chemotherapy, radiation, cardiac and respiratory therapy o infusion services o dialysis ***A copay does not apply when these services are provided by the same provider on the same day as the office visit.***	**No Charge after deductible**
o diagnostic x-rays	**$20** each visit
o advanced diagnostic imaging services ***Your payment responsibility is waived if services are billed as part of an emergency room visit.***	**$100 for each visit**
Other In-Network Services	**You Pay**
You will pay all the costs associated with your care until you have paid $250 for an individual and $500 for family in one plan year for certain services as listed below. This is known as your deductible. o If two people are covered under your plan, each of you will pay the first $250 of the cost of your care ($500 total). o If three or more people are covered under your plan, together you will pay the first $500 of the cost of your care. However, the most one family member will pay is $250.	
Autism Spectrum Disorder (ASD) – For children from age 2 through 6	
o diagnosis and treatment of autism spectrum disorder including: o behavioral health treatment* o psychiatric care o therapeutic care** o pharmacy care o psychological care * ***Mental Health Services*** ** ***Unlimited physical, occupational and speech therapy.***	Member cost shares will be dependent on the services rendered.
o applied behavioral analysis o Unlimited maximum	**10%** of the amount the health care professionals in our network have agreed to accept for their services after deductible
Early Intervention – For children from birth through age 2	
o unlimited per member per calendar year up to age 3	Member cost shares will be dependent on the services rendered.
Other Outpatient Services	
o hospice care	**No Charge after deductible**
o home health care (100 visits)	**No Charge after deductible**

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o durable medical equipment o prosthetic devices o private duty nursing (16 hours per member per plan year) o medical appliances, supplies and medications, including infusion medications o ambulance travel ***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.***	**10%** of the amount the health care professionals in our network have agreed to accept for their services after deductible
For benefits listed with specific limits - all services received during the Plan Year July 1, 2015 through June 30, 2016 for that benefit are applied to that limit (whether received in or out-of-network).	

In-Network Services	You Pay
Outpatient Surgery in a Hospital or Facility	
o surgery	**$150 for each visit**
Inpatient Stays in a Network Hospital or Facility	
o semi-private room o private room when approved when approved in advance o intensive or coronary care unit ***You do not have to pay another inpatient copay if you are readmitted for the same or related condition within less than 90 days from when you went home.***	**$200** per confinement*
o skilled nursing facility care (100 days for each admission) o physician, nursing and other medically necessary professional services in the hospital including anesthesia, surgical and maternity delivery services	**No charge; after deductible**
Emergency Care	
o true emergency care visits in or out of the service area ***Waived if admitted directly to the hospital.***	**$200** for each visit to an emergency room*
Infertility Services	
Services for the evaluation and treatment of infertility for you or your covered spouse. Artificial insemination benefits are limited to two procedures per lifetime. Covered fertilization services include in-vitro, GIFT or ZIFT procedures. **Please refer to your Summary of Benefits for other eligible expenses. RX do require Prior Authorization.**	**No Charge; after deductible**
For benefits listed with specific limits - all services received during the Plan Year July 1, 2015 through June 30, 2016 for that benefit are applied to that limit (whether received in or out-of-network).	

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.

Once you have reached this amount, when you receive covered services we will pay 80% 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.

Out-of-Pocket Maximums

What You Will Pay for Covered Services in One Plan Year (July 1- June 30)

When using network professionals
If you are the only one covered by your plan, you will pay $1,500 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 $1,500 ($3,000 total).
- If three or more people are covered under your plan, together you will pay $3,000. However, no family member will pay more than $1,500 toward the limit.

When not using network professionals
If you are the only one covered by your plan, you will pay $2,750 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 $2,750($5,500 total).
- If three or more people are covered under your plan, together you will pay $5,500. However, no family member will pay more than $2,750 toward the limit.

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

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.

Your prescription drug benefits

Pharmacy network

Anthem's prescription drug program manages more than 400 million prescriptions each year. With a broad retail pharmacy network, home delivery and a specialty unit that dispenses high-cost, biotech therapies, our comprehensive approach helps you manage your pharmacy benefits.

Some members have a tiered drug list/formulary, or list of covered medications, which assigns drugs to specific tiers based on cost. Tier 1 drugs have the most affordable copay. Tier 2 drugs cost slightly more, and Tier 3 drugs have the highest copay amounts.

Your Prescription Drug Plan	Tier 1 Copay	Tier 2 Copay	Tier 3 Copay
Up to a 30-day medication supply at participating retail pharmacies	$15	10% of drug cost with a minimum $40 copay; maximum $100 copay	10% of drug cost with a minimum $60 copay; maximum copay $100
Up to a 90-day medication supply delivered to your home	$15	10% of drug cost with a minimum $80 copay; maximum $200 copay	10% of drug cost with a minimum $180 copay; maximum copay $300
Prescription Drug cost share (copay & coinsurance) accumulate towards the plan year out-of-pocket maximum under the KeyCare Medical Plan.			

Generics are often cheaper because they're based on existing FDA-approved brand-name drugs, and manufacturers don't have to pay as much for research, development, or advertising. Your prescription drug copayments are designed so that you'll pay less out-of-pocket when your prescriptions are filled with generic drugs. So for less money, you get an equally effective medication. Participating pharmacies will always dispense a generic drug if a generic drug is available. ***If you or your doctor requests a brand-name drug when a generic is available, you will pay your usual copayment for the generic drug plus the difference in the allowable charge between the generic and brand name drug.***