

Summary of Benefits

This is only a brief summary of your coverage. Benefits apply when care is **medically necessary**. Services are covered up to the Maximum Allowable Benefit (MAB). Network Providers agree to accept the MAB as payment in full.

Service Received	Your Share of the Cost
These services MUST be provided by or referred by your Primary Care Provider (PCP)	
Preventive Care <ul style="list-style-type: none"> ▪ Immunization, lead screening, PSA (prostate screening) • Routine physical exams for babies, children and adults, including family planning visits • Routine hearing exams See “Other Services” for additional Preventive Care information	Covered in full \$20 per visit to your PCP \$40 per visit to any Specialist \$20 per visit to your PCP \$40 per visit to any Specialist
Other Outpatient Care <ul style="list-style-type: none"> • Medical exams, injections (including allergy injections), office surgery and anesthesia • Lab, x-ray and ultrasounds • Physical therapy, occupational therapy, or speech therapy-up to 60 visits-combined • Early Childhood Intervention therapy services for children up to age 3 – limited to \$3,200 per member, per calendar year and \$9,600 per member’s lifetime 	\$20 per visit to your PCP \$40 per visit to any Specialist or Network Walk-in-Center Covered in full \$40 per visit \$20 per visit to your PCP \$40 per visit to any Specialist
Service Received	Your Share of the Cost
<ul style="list-style-type: none"> • CT Scan, MRI, outpatient facility fees • Surgery in the outpatient department of a hospital or in a hospital’s ambulatory surgery center 	Subject to:
Inpatient Care (as a bed patient in an acute care hospital) <ul style="list-style-type: none"> • Semi-private room and board • Physician in-hospital care, surgery, delivery, anesthesia, lab, X-ray, CT scan, MRI, medical supplies, medication and physical, occupational and speech therapy 	\$1,000 deductible per member, no more than \$3,000 per family per calendar year And
Skilled Nursing Facility Care <ul style="list-style-type: none"> • Up to 100 inpatient days per member per calendar year 	20% coinsurance up to \$2,000 per member, no more than \$6,000 per family per calendar year
Physical Rehabilitation Facility <ul style="list-style-type: none"> • Up to 60 inpatient days per member, per calendar year 	
Durable Medical Equipment (DME) up to \$ 3,000 per member per calendar year. This limit does not apply to prosthetics that replace an arm or leg in whole or in part	
These services DO NOT require a PCP referral as long as you use network providers.	
Other Services <ul style="list-style-type: none"> • Routine vision exam -one exam every each two years. • OB/GYN care (performed by a network OB/GYN provider) <ul style="list-style-type: none"> - Exam - Maternity care (routine prenatal, delivery and postpartum) - Mammogram and Pap smear • Chiropractic visit - Chiropractic X-ray 	\$40 per visit \$20 per visit Subject to deductible and coinsurance Covered in full \$40 per visit Covered in full
These services DO NOT require a PCP referral for medical emergencies and urgent care.	
Emergency Room (ER) or Urgent Care Facility Visit <ul style="list-style-type: none"> • ER charge (the copayment is waived if you are admitted). • Urgent Care facility charge • ER/Urgent Care physician fee, CT scan, MRI, medical supplies, etc 	\$150 per visit \$50 per visit Subject to deductible and coinsurance
Ambulance (medically necessary emergency transport only)	Subject to deductible and coinsurance

Service Received	Your Share of the Cost
<p>Outpatient services</p> <ul style="list-style-type: none"> Mental Health visits --unlimited visits per member, per calendar year <p>In-Network, two office visits for diagnosis and three treatment visits are allowed each contract year without clinical review.</p> <ul style="list-style-type: none"> Substance Abuse visits (for detoxification or rehabilitation) unlimited visits per member, per calendar year 	<p>\$20 per visit</p>
<p>Inpatient Services (Inpatient care must be authorized in advance by Anthem at 1-800-228-5975.)</p> <p>Mental Health –unlimited inpatient days per member per, per calendar year</p> <p>Substance Abuse - medically necessary inpatient days for medical detoxification and rehabilitation</p>	<p>Subject to deductible and coinsurance</p>
<p>Prescription Drugs</p>	
<p>Covered medications, diabetic supplies and contraceptive devices purchased at a network retail or mail order pharmacy.</p> <p>Prescriptions may be filled up to a 90-day supply.</p> <ul style="list-style-type: none"> You pay one copay per 30-day supply at a retail You pay additional copays for fills that exceed a 30-day supply. Example: you pay three copays per 90-day supply at a retail you pay one copay per 90-day supply at a mail order pharmacy. <p>Important notes:</p> <ul style="list-style-type: none"> Whenever available, your prescription will be filled generically. If you choose to buy a brand drug, you pay the generic copay, plus the difference in cost between the brand and generic drug. If, due to medical necessity, your physician must prescribe a brand drug, you pay the brand copay. <p>Refer to your prescription drug program flyer for details.</p>	<p>At a Retail Pharmacy</p> <p>\$10 Tier 1 \$30 Tier 2 \$40 Tier 3</p> <p>by Mail Order:</p> <p>\$10 Tier 1 \$60 Tier 2 \$120 Tier 3</p>
<p>Exclusions and Limitations</p>	
<p>The services listed below are not covered by this plan. Complete details on exclusions and limitations are stated in the Subscriber Certificate.</p>	
<p>• Any service that is not medically necessary • Any service required by a third party (court ordered services are covered if all of the other terms of the plan are met) • Cosmetic surgery • Custodial or convalescent care • Educational testing and therapy • Experimental and/or investigational services except as required by law for clinical trials • Hospitalization for conditions that are not covered • Human organ transplants other than those listed in the Subscriber Certificate as Covered Services • Mental health services which do not usually result in favorable modification through short-term therapy • Miscellaneous devices, materials, and supplies, including, but not limited to, manual breast pumps, hearing aids (except children under 19), eyeglasses, contact lenses (except after cataract surgery), dentures and support devices for the feet and corrective shoes • Permanent dental restoration, most oral surgery (general anesthesia, hospital or surgical day care facility charges for dental procedures are covered for certain individuals only to the extent required by law) • Personal comfort items • Radial keratotomy or other surgery to correct vision • Routine podiatry • Services covered by government programs to the extent permitted by law • Services for work-related illness or injury • Sex changes • Services, treatments, procedures or programs for weight or appetite control, weight loss, weight management or control of obesity, except for diabetes education, nutrition counseling, and medically necessary surgical and non-surgical services to treat diseases and ailments caused by or resulting from obesity or morbid obesity•</p>	
<p>Anthem Blue Cross and Blue Shield has the right to recover its costs for care of:</p> <ul style="list-style-type: none"> Injuries which are the responsibility of other parties • Services for which another insurance carrier or Medicare is primary • Services related to illegal conduct 	

This is only a brief summary of your coverage. This summary of benefits is not a contract. It is a general description of the benefits and exclusions of this plan. Complete information about all benefits, limitations and exclusions is in the Subscriber Certificate, which will be mailed to you after you enroll. If you need further information, please call Customer Service at 1-800-870-3122.