

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. However, if you receive self referred services from an out-of-network provider, it is your responsibility to pay the difference between the MAB and the provider's charge.

Service Received	Your Share of the Cost	
You will pay less if these services are provided or referred by your Primary Care Provider (PCP).		
Preventive Care <ul style="list-style-type: none"> Immunization, lead screening, PSA (prostate screening) Routine physical exam for babies, children and adults including family planning visits Routine hearing exam (<i>one exam each year for members 18 years old and younger</i>) <i>See "Other Services" for additional Preventive Care information</i>	PCP Referred Benefits	Self Referred Benefits[⊙]
	Covered in full	Covered up to MAB
Other Outpatient Care <ul style="list-style-type: none"> Medical exam, injections (including allergy injections), office surgery and anesthesia Lab, X-ray and ultrasound Physical therapy, occupational therapy, and speech therapy (<i>up to a combined maximum of \$3,000 per member per calendar year</i>)[⊖] 	\$10 per visit	Subject to: \$500 deductible per member, no more than \$1,500 per family per calendar year [⊙] and 20% coinsurance up to \$1,000 per member, no more than \$3,000 per family per calendar year [⊙]
	Covered in full	
<ul style="list-style-type: none"> CT scan and MRI, outpatient facility fees Surgery in hospital outpatient department or ambulatory surgery center 	\$10 per visit	Subject to: Some self referred benefits are subject to pre-certification requirements. Refer to your Subscriber Certificate for details. Call 1-800-531-4450 to precertify.
	Covered in full	
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, anesthesia, lab, X-ray, CT scan, MRI, medical supplies, medication and physical, occupational and speech therapy 	\$250 deductible per member, no more than \$750 per family per calendar year [⊙]	
Skilled Nursing Facility <i>(up to 100 inpatient days per member per calendar year)</i> [⊖] Physical Rehabilitation Facility <i>(up to 100 inpatient days per member per calendar year)</i> [⊖]		
Durable Medical Equipment (DME) <i>(up to \$ 3,500 per member per calendar year)</i> [⊖]	\$100 DME deductible 20% coinsurance [⊙]	\$100 DME deductible 20% coinsurance [⊙]
These services DO NOT require a PCP referral. Your benefit is determined by whether you choose a network provider or an out-of-network provider.		
Other Services <ul style="list-style-type: none"> Routine vision exam (<i>one exam each year for members 18 years old or younger, one exam every two years for members 19 years old and older</i>) OB/GYN care (performed by an OB/GYN provider) <ul style="list-style-type: none"> Exam Maternity care (routine prenatal, delivery and postpartum) Mammogram and Pap smear Chiropractic visit (<i>12 visits per member per calendar year</i>) <ul style="list-style-type: none"> Chiropractic X-ray 	Network Benefits	Out-of-network Benefits[⊙]
	\$10 per visit	Subject to self referred deductible and coinsurance [⊙]
	\$10 per visit	
	Subject to deductible [⊙]	
Covered in full	Covered up to MAB	
\$10 per visit	Subject to self referred deductible and coinsurance [⊙]	
Covered in full		
These services DO NOT require a PCP referral for medical emergencies as defined by the Subscriber Certificate.		
Emergency Room (ER) Visit <ul style="list-style-type: none"> ER charge (<i>copayment waived if admitted</i>). 	Network Benefits	Out-of-network Benefits[⊙]
	\$75 per visit	Same as Network Benefits
Subject to deductible [⊙]		
Ambulance (medically necessary emergency transport only)		

⊖ Any combination of benefits from either column count toward this maximum. ⊙ Services are covered up to the MAB. Out of network providers may bill you for amounts that exceed the MAB. ⊙ Deductible and coinsurance amounts are shared between both columns.

Mental Health and Substance Abuse. For these services no PCP referral is required, but ALL care must be authorized in advance by Behavioral Health Network (BHN) at 1-800-228-5975. You will pay less if you utilize a network provider.

Outpatient Services	Network Benefits	Out-of-network Benefits ^o
<ul style="list-style-type: none"> Mental Health visits-limited to 20 visits per member, per calendar year[†] Substance Abuse visits-(for detoxification or rehabilitation) limited to 20 visits per member, per calendar year^o 	\$10 per visit	Subject to self referred deductible and coinsurance ^o
Inpatient Services <ul style="list-style-type: none"> Mental Health: limited to 30 inpatient days per member, per calendar year[†] Substance Abuse: <ul style="list-style-type: none"> -medical detoxification-Medically Necessary inpatient days -for substance abuse rehabilitation-limited to \$5,000 per member per calendar year and \$10,000 per lifetime^o 	Subject to deductible ^o	Inpatient and outpatient substance abuse detoxification benefits are limited to \$3,000 per member per year and \$10,000 lifetime maximum per member. ^o

Prescription Drugs

Covered medications, diabetic supplies and contraceptive devices purchased at a network pharmacy	Network Benefits	Out-of-network Benefits ^o
<ul style="list-style-type: none"> Copayment applies to each fill, up to a 30-day supply for both retail and mail order. Example: a 3-month supply through mail order requires 3 copayments. Includes maintenance drugs at a retail or mail order pharmacy <ul style="list-style-type: none"> - Only certain drugs are considered "maintenance" and are available for a supply greater than 30 days. Important notes: <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 needs to prescribe a brand drug, you pay only the formulary or non- formulary brand copay shown on this summary. - Refer to your prescription drug plan flyer for details. 	\$10 copay /generic \$20 copay / formulary brand \$30 copay/non- formulary brand	Not covered

Exclusions and Limitations

The services listed below are not covered by this plan. Please review the Subscriber Certificate for complete details on exclusions and limitations.

Services Not Covered

•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) • Artificial insemination, assisted reproductive technologies and infertility drugs • Claims for services received more than 12 months ago • Complementary and Alternative Therapies/ Medicine • Cosmetic surgery • Custodial or convalescent care • Educational testing and therapy • Experimental and/or investigational services • Hospitalization for conditions that are not covered • Human organ transplants other than those listed in the Subscriber Certificate as covered benefits • 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, breast pump, routine hearing exam and hearing aids (except for children under 19), eyeglasses, contact lenses (except after cataract surgery), dentures and support devices for the feet and corrective shoes • Permanent dental restoration, orthognathic and most oral surgery • 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 • Sterilization reversal • Weight reduction management and control except diabetes education and nutritional counseling

Anthem Blue Cross and Blue Shield has the right to recover its costs for care of:

• 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. You may be subject to pre-existing condition limitations. 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, call Customer Service at 1-800-438-9672.

^o Any combination of benefits from either column count toward this maximum.

ⁿ Services are covered up to the MAB. Out of network providers may bill you for amounts that exceed the MAB.

[†]These limitations do not apply to biologically based mental illness.

[‡] BlueChoice is administered by Anthem Blue Cross and Blue Shield and underwritten by Matthew Thornton Health Plan BC2/T46