

## 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
<b>These services MUST be provided by or referred by your Primary Care Provider (PCP).</b>	
<b>Preventive Care</b> <ul style="list-style-type: none"> <li>Immunization, lead screening, PSA (prostate screening)</li> <li>Routine physical exam including family planning visits and well baby care</li> <li>Routine hearing exam (<i>as needed</i>)</li> </ul> <i>See "Other Services" for additional Preventive Care information</i>	Covered in full  \$15 per visit \$15 per visit
<b>Other Outpatient Care</b> <ul style="list-style-type: none"> <li>Medical exam, injections, and office surgery</li> <li>Lab, X-ray and ultrasound</li> <li>Short term rehabilitative therapy- physical, occupational, or speech (<i>up to 60 visits, any combination, per member, per calendar year</i>)</li> </ul>	\$15 per visit Covered in full  \$15 per visit
<ul style="list-style-type: none"> <li>CT scan and MRI, outpatient facility fees</li> <li>Surgery in hospital outpatient department or ambulatory surgery center</li> </ul>	Subject to:  \$500 deductible per member, no more than \$1,500 family per calendar year
<b>Inpatient Care</b> (as a bed patient in an acute care hospital) <ul style="list-style-type: none"> <li>Semi-private room and board</li> <li>Physician in-hospital care, surgery, anesthesia, lab, X-ray, CT scan, MRI, medical supplies, medication and physical, occupational and speech therapy</li> </ul>	
<b>Skilled Nursing Facility and Rehabilitation Facility Care</b> <i>(limited to 100 days in a skilled nursing facility and 60 days in a rehabilitation facility per member, per calendar year)</i>	
<b>Durable Medical Equipment (DME)</b> <i>[(up to \$3,000 per member per calendar year)]</i>	
<b>These services DO NOT require a PCP referral as long as you use designated network providers.</b>	
<b>Other Services</b> <ul style="list-style-type: none"> <li>Routine vision exam (<i>one exam every two years</i>)</li> <li>OB/GYN care (performed by an OB/GYN provider)               <ul style="list-style-type: none"> <li>Exam</li> <li>Mammogram and Pap smear</li> </ul> </li> <li>Chiropractic visit               <ul style="list-style-type: none"> <li>chiropractic X-ray</li> </ul> </li> </ul>	\$15 per visit  \$15 per visit Covered in full \$15 per visit Covered in full
<ul style="list-style-type: none"> <li>Maternity care (routine prenatal, delivery and postpartum)</li> </ul>	Subject to deductible
<b>These services DO NOT require a PCP referral for medical emergencies as defined by your Subscriber Certificate.</b>	
<b>Emergency Room (ER) Visit</b> <ul style="list-style-type: none"> <li>ER charge</li> </ul>	\$100 per visit
<ul style="list-style-type: none"> <li>ER physician fee, CT scan, MRI, medical supplies, etc.</li> </ul>	Subject to deductible
<b>Ambulance</b> (medically necessary emergency transport only)	

**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.**

<b>Mental Health and Substance Abuse (MH/SA)</b> <ul style="list-style-type: none"> <li>• Outpatient services <ul style="list-style-type: none"> <li>- Visit/consultation</li> </ul> </li> </ul>	\$15 per visit
<ul style="list-style-type: none"> <li>• Inpatient services <ul style="list-style-type: none"> <li>- Semi-private room &amp; board</li> <li>- MH/SA physician visit</li> </ul> </li> </ul>	Subject to deductible

**Prescription Drugs**

<p>Covered medications, diabetic supplies and contraceptive devices purchased at a network pharmacy</p> <ul style="list-style-type: none"> <li>• Includes maintenance drugs at a retail and or mail order pharmacy. Only certain drugs are considered “maintenance” and are available for a supply greater than 30 days.</li> <li>• Important notes: <ul style="list-style-type: none"> <li>- Whenever available, your prescription will be filled generically. If you <b>choose</b> to buy a brand drug, you pay the generic copay, plus the difference in cost between the brand and generic drug.</li> <li>- If, <b>due to medical necessity</b>, your physician needs to prescribe a brand drug, you pay only the formulary or non-formulary brand copay shown on this summary.</li> <li>- Refer to your prescription drug program flyer for details.</li> </ul> </li> </ul>	<p>\$10 copay /generic  \$25 copay / formulary brand  \$40 copay /non-formulary brand</p> <p><i>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.</i></p>
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**Exclusions and Limitations**

The services listed below are not covered by this plan. Please review your 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) • 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, hearing aids, 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. 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 1-800-870-3122.

□HMO Blue New England and Network Blue are administered by Anthem Blue Cross and Blue Shield and underwritten by Matthew Thornton Health Plan HNE/T4