BlueChoice® New England† POS 80/20

Anthem

250 POS Summary of Benefits – Plan Year

*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 services from a non-network provider, under Self Referred benefits, it is your responsibility to pay the difference between the MAB and the provider's charge.*

Service Received	Your Share of the Cost	
You do not need a referral from your Primary Care Provider. Your benefit is determined by whether you choose a provided in your designated network or an out-of-network provider.		
Preventive Care	**In Network Benefits**	**Out of Network Benefits℠**
• Immunization, lead screening, PSA (prostate screening), mammograms and PAP smears • Routine physical exam for babies, children and adults including family planning visits • Routine hearing exam • Routine vision exam *(one exam each calendar year per member)*	Covered in full	Covered up to MAB Subject to: $100 deductible per member, no more than $300 per family per plan year and 20% coinsurance up to $400 per member, no more than $1,200 per family per plan year Out-of-pocket maximum $500 per member, no more than $1,500 per family per plan year Some benefits are subject to precertification requirements. Refer to your Subscriber Certificate for details. Call 1-800-531-4450 to precertify.
Other Outpatient Care • Medical exam, injections (including allergy injections), office surgery, and anesthesia • Early Childhood Intervention therapy services for children up to age 3	$20 per visit to your PCP $20 per visit to any SPC	
• Lab, X-ray and ultrasound • Short term rehabilitative therapy - physical, occupational, or speech *(unlimited)*☺ • CT scan, MRI, PET scan, MRA outpatient facility fees	Covered in full	
• Surgery in hospital outpatient department or ambulatory surgery center	$250 copayment per surgery	
Inpatient Care (as a bed patient in an acute care hospital) • 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.	$250 copayment per admission Covered in full	
Skilled Nursing Facility and Rehabilitation Facility Care *(limited to 100 combined days in a skilled nursing facility and rehabilitation facility per member per calendar year)*☺	$250 copayment per admission	
Durable Medical Equipment (DME) *(Unlimited)*☺ $200 deductible for external prosthetics	Covered in full	
Other Services • Chiropractic visit *(20 visits per member per plan year)* • Chiropractic X-ray • OB/GYN care (performed by an OB/GYN provider) - Exam - Maternity care (routine prenatal, delivery and postpartum)	$20 per visit Covered in full $20 per visit $250 copayment per admission	
Emergency Room or Urgent Care Visit • ER facility charge *(copayment waived if admitted)* • Urgent Care facility charge • ER/Urgent Care physician fee, CT Scan, MRI, medical supplies, etc.	$150 per visit $75 per visit Covered in full	Same as Network Benefits
Ambulance (medically necessary emergency transport only)	Covered in full	Covered in full up to MAB

☺ 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.

Service Received	Your Share of the Cost	
	In Network Benefits	**Out of Network Benefits**[SM]
Mental Health and Substance Abuse • Outpatient services - Visit/consultation	$20 copayment per visit	Subject to deductible and coinsurance
• Inpatient services - Semi-private room & board - Physician visit	$250 copayment per admission Covered in full	
Maximums for Services Subject to $250 Copayment		
Individual Maximum Family Maximum	$250 per member per plan year $500 per family per plan year	Not applicable. All services subject to out of network deductible and coinsurance.
Out of Pocket Limitations		
Medical Out-of-Pocket Limitation The Out-of-Pocket Limit includes all Deductibles, Coinsurance, and Copayments you pay during a Calendar Year. It does not include your Premium, amounts over the Maximum Allowable Benefit, or charges for non-covered services.	Once the Out-of-Pocket Limit is satisfied, you will not have to pay additional Deductibles, Coinsurance or Copayments for the rest of the Plan Year. $6,350 per Member, per Plan Year $12,700 per family, per Plan Year	Not applicable. All services subject to out of network deductible and coinsurance.
Prescription Drugs		
	Network Benefits	**Out-of-Network Benefits**[SM]
Covered medications, diabetic supplies and contraceptive devices purchased at a network pharmacy • Copayment applies to each fill, up to a 30-day supply for retail • Includes maintenance drugs at a retail or mail order pharmacy • Only certain drugs are considered "maintenance" and are available for a supply greater than 30 days. • Important notes: - If you choose to buy a brand drug, you pay the brand copay Refer to your prescription drug program flyer for details.	**Retail** (*30 day supply):* $10 copay /tier 1 $30 copay / tier 2 $50 copay / tier 3 90 day supply available at retail for 3 copays **Mail Order** (*90 day supply):* $20 copay /tier 1 $60 copay / tier 2 $100 copay / tier 3	Same as network benefits

Other	
Fitness Club Reimbursement Vision Hardware (per member per plan year)	$200 maximum reimbursement (limited to one member per enrolled household per plan year) Lenses (*Maximum Reimbursement Amount)* $20 Single $30 Bifocal $40 Trifocal $75 Lenticular $75 Contacts Frames (M*aximum Reimbursement Amount)* $100 Frame

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, 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, orthographic 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 • Sterilization reversal

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.

Language Access Services:

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (855) 333-5735.

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

(TTY/TDD: 711)

Arabic *(العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على* (855) 333-5735

Armenian (*հայերեն*). *Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝* (855) 333-5735

Chinese (中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (855) 333-5735

Farsi *(فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره* (855) 333-5735 *تماس بگیرید.*

French (Français): Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (855) 333-5735.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (855) 333-5735.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (855) 333-5735

(Japanese)（日本語）: この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(855) 333-5735 にお電話ください。

Language Access Services:

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (855) 333-5735 로 문의하십시오.

(Navajo) (Din4): Díí naaltsoos biká'ígíí łahgo bína'ídíłkidgo ná bohónéedzą́ dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínízingo kojį' hodíílnih (855) 333-5735.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (855) 333-5735.

(Punjabi) (ਪੰਜਾਬੀ): *ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ,* (855) 333-5735 *ਤੇ ਕਾਲ ਕਰੋ।*

(Russian) (Русский): *если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (855) 333-5735.*

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Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (855) 333-5735.

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (855) 333-5735.

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