

POS Site of Service \$100 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 provider in your designated network or an out-of-network provider.		
Preventive Care	In Network Benefits	Out of Network Benefits [Ⓢ]
<ul style="list-style-type: none"> 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 (<i>one exam each calendar year per member</i>) 	Covered in full	Covered up to MAB Subject to: \$100 deductible per member, no more than \$300 per family per plan year
Other Outpatient Care <ul style="list-style-type: none"> 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	and
<ul style="list-style-type: none"> Diagnostic lab services at participating SOS facilities Diagnostic imaging – x-rays, ultrasounds and chiropractic x-rays at participating SOS facilities High Cost diagnostic imaging such as MRI/CT Scans at participating SOS facilities Outpatient surgery at Ambulatory Surgical Center at participating SOS facilities Short term rehabilitative therapy - physical, occupational, or speech (<i>unlimited</i>)[Ⓢ] 	Covered in full Covered in full Covered in full Covered in full Covered in full	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
<ul style="list-style-type: none"> Surgery at non-participating hospital outpatient department or ambulatory surgery center High cost diagnostic imaging such as MRI/CT Scans at non-participating SOS facilities or hospitals Diagnostic Lab services at non-participating facility or hospitals Diagnostic imaging X-rays, ultrasounds and chiropractic x-rays at non-participating SOS facility or hospitals 	\$250 copay per visit \$250 copay per visit \$50 copay per visit \$125 copay per visit	Some benefits are subject to precertification requirements. Refer to your Subscriber Certificate for details. Call 1-800-531-4450 to precertify.
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. 	\$100 per member / \$200 per family per plan year deductible	
Skilled Nursing Facility and Rehabilitation Facility Care <i>(limited to 100 combined days in a skilled nursing facility and rehabilitation facility per member per calendar year)</i> [Ⓢ]		
Durable Medical Equipment (DME) <i>(Unlimited)</i> [Ⓢ] \$200 deductible for external prosthetics	Covered in full	
Other Services <ul style="list-style-type: none"> Chiropractic visit (<i>20 visits per member per plan year</i>) OB/GYN care (performed by an OB/GYN provider) <ul style="list-style-type: none"> Exam Maternity care (routine prenatal, delivery and postpartum) 	\$20 per visit \$20 per visit \$100 Deductible	

Emergency Room or Urgent Care Visit			
<ul style="list-style-type: none"> ER facility charge (<i>copayment waived if admitted</i>) 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
Service Received		Your Share of the Cost	
		In Network Benefits	Out of Network Benefits[Ⓢ]
Mental Health and Substance Abuse			Subject to deductible and coinsurance
<ul style="list-style-type: none"> Outpatient services <ul style="list-style-type: none"> Visit/consultation Inpatient services <ul style="list-style-type: none"> Semi-private room & board Physician visit 		\$20 copayment per visit	
		Subject to deductible	
Maximums for Services Subject to \$250 Deductible			
Individual deductible	\$100 per member per plan year	Not applicable. All services subject to out of network deductible and coinsurance.	
Family deductible	\$200 per family per plan year		
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[Ⓢ]
Covered medications, diabetic supplies and contraceptive devices purchased at a network pharmacy		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	Same as network benefits
<ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> If you choose to buy a brand drug, you pay the brand copay 		Mail Order (90 day supply): \$20 copay /tier 1 \$60 copay / tier 2 \$100 copay / tier 3	
Refer to your prescription drug program flyer for details.			

Other

Fitness Club Reimbursement	\$200 maximum reimbursement (limited to one member per enrolled household per plan year)
Vision Hardware (per member per plan year)	Lenses (<i>Maximum Reimbursement Amount</i>) \$20 Single \$30 Bifocal \$40 Trifocal \$75 Lenticular \$75 Contacts Frames (<i>Maximum Reimbursement Amount</i>) \$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.

☺ 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.

† BlueChoice New England is administered by Anthem Blue Cross and Blue Shield and underwritten by Matthew Thornton Health Plan