

HMO 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.*

Service Received	Your Share of the Cost
You do not need a referral from your Primary Care Provider, however you must receive covered services in the Access Blue Network.	
Preventive Care <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 per member per calendar year</i>) 	Covered in full
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 Specialist
<ul style="list-style-type: none"> Diagnostic lab services at participating SOS facilities Diagnostic imaging – x-rays and ultrasounds 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- <i>physical, occupational, or speech (up to 60 visits, any combination, per member, per plan year)</i> 	Covered in full Covered in full Covered in full Covered in full Covered in full
<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 and ultrasounds at non-participating SOS facility or hospitals 	\$250 copay \$250 copay \$50 copay \$125 copay
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 or rehabilitation facility per member, per calendar year)</i>	\$100 per member / \$200 per family per plan year deductible

Durable Medical Equipment (DME) <i>Unlimited</i> \$200 deductible for external prosthetics	Covered in full
Other Services <ul style="list-style-type: none"> OB/GYN care (<i>performed by an OB/GYN provider</i>) <ul style="list-style-type: none"> Exam Maternity care (routine prenatal, delivery and postpartum) Chiropractic visit (<i>20 visits per member per plan year</i>) Chiropractic X-ray 	\$20 per visit \$100 Deductible \$20 per visit \$125 copay
Emergency Room or Urgent Care Center 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
Ambulance (<i>medically necessary emergency transport only</i>)	Covered in full
Service Received	Your Share of the Cost
You do not need a referral from your Primary Care Provider, however you must receive covered services in the Access Blue Network.	
Mental Health and Substance Abuse <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 \$100 per member / \$200 per family per plan year deductible
Maximum for Services Subject to \$250 Deductible	
Individual Family	\$100 per member per plan year \$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

Prescription Drugs

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 at retail for 3 copayments

Mail Order (90 day supply):

\$20 copay / tier 1
\$60 copay / tier 2
\$100 copay / tier 3

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 (Maximum Reimbursement Amount)

\$20 Single
\$30 Bifocal
\$40 Trifocal
\$75 Lenticular
\$75 Contacts

Frames (Maximum Reimbursement Amount)

\$30 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, 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 • 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

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