# POS BlueChoice® New England†

Anthem

## Summary of Benefits – Calendar 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<br>• Routine physical exam for babies, children and adults including family planning visits<br>• Routine hearing exam<br>• Routine vision exam *(one exam per calendar year under age 19, one exam every two calendar years for age 19 and over)* | Covered in full | Covered up to MAB<br><br>Subject to:<br><br>$100 deductible per member, no more than $300 per family per calendar year•<br><br>and<br><br>20% coinsurance up to $400 per member, no more than $,1200 per family per calendar year•<br><br>Out-of-pocket maximum $500 per member, no more than $1,500 per family per calendar year.<br><br>Some benefits are subject to precertification requirements. Refer to your Subscriber Certificate for details. Call 1-800-531-4450 to precertify. |
| **Other Outpatient Care**<br>• Medical exam, office surgery, and anesthesia<br>• Early Childhood Intervention therapy services for children up to age 3<br>• Lab, X-ray, ultrasound, injections<br>• Short term rehabilitative therapy- physical, occupational, or speech (*unlimited per member per calendar year*)☺<br>• CT scan, MRI, PET scan, MRA outpatient facility fees<br>• Surgery in hospital outpatient department or ambulatory surgery center | $15 copayment per visit<br><br>$15 copayment per visit<br><br>Covered in full<br><br>Covered in full<br><br>Covered in full<br>Covered in full | |
| **Inpatient Care** (as a bed patient in an acute care hospital)<br>• Semi-private room and board<br>• Physician in-hospital care, surgery, delivery, anesthesia, lab, X-ray, CT scan, MRI, medical supplies, medication and physical, occupational and speech therapy | Covered in full<br><br>Covered in full | |
| **Skilled Nursing Facility and Rehabilitation Facility Care** (*limited to 100 days for each per member, per calendar year*)☺ | Covered in full | |
| **Durable Medical Equipment (DME)**<br>*unlimited* | Covered in full | |
| **Other Services**<br>• Chiropractic visit (12 visits per member per calendar year)<br>- Chiropractic X-ray<br>• OB/GYN care (performed by an OB/GYN provider)<br>- Exam<br>- Maternity care (routine prenatal, delivery and postpartum) | $15 copayment per visit<br>Covered in full<br><br>$15 copayment per visit<br>Covered in full | |
| **Emergency Room (ER) or Urgent Care Center Visit**<br>• ER/Urgent Care charge *(ER copayment waived if admitted)*<br>• ER/Urgent Care physician fee, CT scan, MRI, medical supplies, etc. | $75 copayment per visit<br>Covered in full | Same as Network Benefits |
| **Ambulance** (medically necessary emergency transport only | Covered in full | Covered in full up to MAB |
| **Mental Health and Substance Abuse**<br>Outpatient services<br>- Visit/consultation | $15 copayment per visit | Subject to deductible and coinsurance |
| Inpatient services<br>- Semi-private room & board<br>- Physician visit | Covered in full | |



☺ 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.

## Prescription Drugs

| | Network Benefits | Out-of-Network Benefits[ॐ] |
|---|---|---|
| Covered medications, diabetic supplies and contraceptive devices purchased at a network pharmacy<br><br>• Copayment applies to each fill, up to a 30-day supply for retail<br>• Includes maintenance drugs at a retail or mail order pharmacy<br>• Only certain drugs are considered "maintenance" and are available for a supply greater than 30 days.<br><br>• Important notes:<br>- If you choose to buy a brand drug, you pay the brand<br><br>Refer to your prescription drug program flyer for details. | **Retail** *(30 day supply):*<br>$10 copay / tier 1<br>$15 copay / tier 2<br><br>90 day supply available at retail for 3 copays<br><br>**Mail order** *(90-day supply):*<br>$1 copay / tiers 1 & 2 | Same as network benefits |

## Other

| | |
|---|---|
| Fitness Club Reimbursement | $200 maximum reimbursement (limited to one member per enrolled household per calendar year) |
| Vision Hardware<br>(per member every two years) | $100 maximum reimbursement for frames and lenses |

## Out of Pocket Limitations

| | | |
|---|---|---|
| **Medical Out-of-Pocket Limitation**<br>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.<br>$6,350 per Member, per Calendar Year $12,700 per family, per Calendar Year | Not applicable.<br>All services subject to out of network deductible and coinsurance. |

## 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, 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

**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.

ॐServices 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