

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. 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 per calendar year under age 19, one exam every two calendar years for age 19 and over</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	\$25 per visit to your PCP \$35 per visit to any specialist	and
<ul style="list-style-type: none"> Medical exam, office surgery, and anesthesia Early Childhood Intervention therapy services for children up to age 3 (<i>limited to \$3,200 per member, per plan year and \$9,600 per member's lifetime</i>) Lab, X-ray, ultrasound, injections Short term rehabilitative therapy - physical, occupational, or speech (<i>unlimited, per member, per plan year</i>)⁹ CT scan, MRI, PET scan, MRA outpatient facility fees 	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 in hospital outpatient department or ambulatory surgery center 	\$300 copayment per surgery	
Inpatient Care (as a bed patient in an acute care hospital)	\$300 copayment per admission	Some benefits are subject to precertification requirements. Refer to your Subscriber Certificate for details. Call 1-800-531-4450 to precertify.
<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. 	Covered in full	
Skilled Nursing Facility and Rehabilitation Facility Care	\$300 copayment per admission	
Durable Medical Equipment (DME)	Covered in full	
Other Services	\$35 per visit Covered in full	
<ul style="list-style-type: none"> Chiropractic visit (<i>12 visits per member per plan year</i>) Chiropractic X-ray OB/GYN care (performed by an OB/GYN provider) <ul style="list-style-type: none"> Exam Maternity care (routine prenatal, delivery and postpartum) 	\$25 per visit \$300 copayment per admission	
Emergency Room or Urgent Care Visit	\$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

⁹ 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

Service Received	Your Share of the Cost	
	In Network Benefits	Out of Network Benefits
Mental Health and Substance Abuse		
<ul style="list-style-type: none"> Outpatient services <ul style="list-style-type: none"> Visit/consultation 	\$25 copayment per visit	Subject to deductible and coinsurance
<ul style="list-style-type: none"> Inpatient services <ul style="list-style-type: none"> Semi-private room & board Physician visit 	\$300 copayment per admission Covered in full	
Prescription Drugs		
	Network Benefits	Out-of-Network Benefits
<p>Covered medications, diabetic supplies and contraceptive devices purchased at a network pharmacy</p> <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 <p>Refer to your prescription drug program flyer for details.</p>	<p>Retail (30 day supply): \$10 copay /tier 1 \$30 copay / tier 2 \$50 copay / tier 3</p> <p>90 day supply available at retail for 3 copays</p> <p>Mail Order (90 day supply): \$20 copay /tier 1 \$60 copay / tier 2 \$100 copay / tier 3</p>	Same as network benefits
Maximums for Services Subject to \$300 Copayment		
Individual Maximum	\$300 per member per plan year	Not applicable. All services subject to out of network deductible and coinsurance.
Family Maximum	\$600 per family per plan year	
Other		
Fitness Club Reimbursement	\$200 maximum reimbursement (limited to one member per enrolled household per plan year)	
Vision Hardware (per member every two plan years)	\$100 maximum reimbursement for frames and lenses	
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		
<ul style="list-style-type: none"> 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:		
<ul style="list-style-type: none"> 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.