Matthew Thornton Blue℠†

Anthem

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.*

Service Received	Your Share of the Cost
These services MUST be provided by or referred by your Primary Care Provider (PCP).	
Preventive Care • Immunization, lead screening, PSA (prostate screening) • Routine physical exam for babies, children and adults including family planning visits • Routine hearing exam *(one exam each year for members 18 years old and younger)* *See "Other Services" for additional Preventive Care information*	Covered in full $20 per visit $20 per visit
Other Outpatient Care • Medical exam, injections (including allergy injections), office surgery and anesthesia • Lab, X-ray and ultrasound • Physical therapy, occupational therapy, and speech therapy *(up to a combined maximum of $3,000 per member per calendar year*)	$20 per visit Covered in full $20 per visit
• CT scan and MRI, outpatient facility fees • Surgery in hospital outpatient department or ambulatory surgery center	Subject to deductible and coinsurance: $1,000 deductible per member, no more than $3,000 per family per calendar year 20% coinsurance up to $2,000 per member, no more than $6,000 per family per calendar year
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	
Skilled Nursing Facility *(up to 100 inpatient days per member per calendar year)* **Physical Rehabilitation Facility** *(up to 100 inpatient days per member per calendar year)*	
Durable Medical Equipment (DME) *(up to $ 3,500 per member per calendar year)*	$100 DME deductible 20% coinsurance
These services DO NOT require a PCP referral as long as you use network providers.	
Other Services • Routine vision exam *(one exam each year for members 18 years old or younger, one exam every two years for members 19 years old and older)* • Chiropractic visit (no benefit for non-network providers) *(limited to 12 visits per member per calendar year)* - Chiropractic Xray • OB/GYN care (performed by an OB/GYN provider) - Exam - Mammogram and Pap smear	$20 per visit $20 per visit Covered in full $20 per visit Covered in full
- Maternity care (routine prenatal, delivery and postpartum)	Subject to deductible and coinsurance
These services DO NOT require a PCP referral for medical emergencies as defined by the Subscriber Certificate.	
Emergency Room (ER) Visit • ER charge *(copayment waived if admitted)*	$100 per visit
• ER physician fee, CT scan, MRI, medical supplies, etc. **Ambulance** (medically necessary emergency transport only)	Subject to deductible and coinsurance

Mental Health and Substance Abuse **For these services no PCP referral is required, but ALL care must be authorized in advance by Behavioral Health Network (BHN) at 1-800-228-5975.**	
Outpatient Services • Mental Health visits-limited to 20 visits per member, per calendar year¬ • Substance Abuse visits-(for detoxification or rehabilitation) limited to 20 visits per member, per calendar year	$10 per visit
Inpatient Services • Mental Health: limited to 30 inpatient days per member, per calendar year¬ • Substance Abuse: -medical detoxification-Medically Necessary inpatient days -for substance abuse rehabilitation-limited to $5,000 per member per calendar year and $10,000 per lifetime	Subject to deductible and coinsurance
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 both retail and mail order. Example: a 3-month supply through mail order requires 3 copayments. • 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: - Whenever available, your prescription will be filled generically. If you **choose** to buy a brand drug, you pay the generic copay, plus the difference in cost between the brand and generic drug. - If, **due to medical necessity**, your physician needs to prescribe a brand drug, you pay only the formulary or non-formulary brand copay shown on this summary. - Refer to your prescription drug program flyer for details.	$10 copay /generic $25 copay/formulary brand $40 copay /non-formulary brand
Exclusions and Limitations	
The services listed below are not covered by this plan. Please review the 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) • Artificial insemination, assisted reproductive technologies and infertility treatments • 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, breast pump, routine hearing exam and 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 • Weight reduction management and control except diabetes education and nutritional counseling	
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. You may be subject to pre-existing condition limitations. 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 1-800-870-3057.

¬These limitations do not apply to biologically based mental illness.

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