Your Anthem Benefits

Anthem

Association Option 88
Blue Access℠ (PPO)
Summary of Benefits

Covered Benefits	Network	Non-Network
Deductible (Single/Family) *(Applies only to percent (%) copayments)*	$100/$200	$300/$600
Out-of-Pocket Maximum (Single/Family)	$500/$,1000	$1,000/$2,000
Physician Office Services Including Office Surgeries, allergy serum and injections[1] • Allergy testing	$10 Additional 20%	40% 40%
Preventive Care Medical History Mammography[1], Pelvic Exams, Pap testing and PSA tests Immunizations[1] Annual diabetic eye exam Annual Vision and Hearing exams	$10	40%
Outpatient Physical Medicine Therapies (Combined Network & Non-Network limits apply) Physical/Occupational therapy: 20/20 visit limit Spinal manipulations: 12 visit limit Speech therapy: 20 visit limit	Copayments based on place of service	Copayments based on place of service
Inpatient Services Unlimited days except for: 60 days Network/Non-Network combined for physical medicine/rehab 180 days Network/Non-Network combined for skilled nursing facility	20%	40%
Outpatient Surgery Hospital/Alternative Care Facility	20%	40%
Other Outpatient Services Hospital/Alternative Care Facility	20%	40%
Inpatient and Outpatient Professional Charges	20%	40%
Home Care Services 30 visits Non-Network limit for Home Care, excludes IV therapy	20%	40%
Hospice Services	Covered in full	Covered in full
Emergency and Urgent Care: **Emergency Care in Emergency Room** *(covers all services, copayment waived if admitted, then inpatient copayment applies)* **Urgent Care Facility**	 $75 $35	 $75 $35
Ambulance Services	20%	20%
Maternity Services	20%	40%

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Covered Benefits	Network	Non-Network
Mental Health and Substance Abuse[2] (limits and maximums apply) Inpatient 20 Network days Outpatient 30 Network visits 10 Non-network mental health visits Inpatient and outpatient substance abuse $550 calendar year Non-network maximum. • Autism: $500 monthly maximum for children age 2-21 (Substance abuse rehabilitation programs are limited to two per lifetime Network and Non-Network combined.) Call 1 (800) 788-4003 for authorized referral.	20% Copayments based on place of service	40% (mental health not covered) 40%
Lifetime Maximum (Combined Network and Non-Network)	$5 million	$5 million
Human Organ and Tissue Transplants except Kidney and Cornea transplants[3] A separate $1 million lifetime maximum applies (Combined Network and Non-Network)	Covered in full	50%
Medical Supplies, Equipment and Appliances	20%	40%
Prescription Drug Options:** **Network Retail Pharmacies:** (30-day supply) Includes diabetic test strip	$8 generic/$15 brand $25 non-form generic/brand	50%, min $25*
Anthem Rx Direct Mail Service: (90-day supply) Includes diabetic test strip	$16 gen form/$30 brand form $40 non-form generic/brand	Not covered

Notes:

- *All deductibles and copayments apply toward the Out-of-Pocket Maximum (except prescription drug, human organ and tissue transplants, excluding kidney and cornea, and flat dollar copayments for Preventive Care, Physician Office Services and Urgent Care).*
- *Deductible(s) apply only to covered services listed with a percentage (%) copayment excluding prescription drugs and allergy testing **(Network)**.*
- *Network and Non-network deductibles, copayments and out-of-pocket maximums are separate and do not accumulate toward each other.*
- *Dependent age: to the end of the calendar year in which the child attains age 19; or the end of the calendar year in which the child attains age 24 if the child qualifies as a Federal tax exemption.*
- *Certain diabetic and asthmatic supplies are covered in full at network pharmacies except diabetic test strips.*

[1] *These covered services are covered in full if you have a flat dollar copayment and if rendered without an office visit.*
[2] *Mental health/substance abuse must be authorized by the mental health administrator for services to be covered at the highest benefit level. Refer to Schedule of Benefits for limitations.*
[3] *Kidney and Cornea are treated the same as any other illness and subject to the medical benefits and lifetime maximum.*
* *Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.*

***If applicable, all prescription drug expenses (Network/Non-network, Retail/Mail-service combined) apply to the per individual deductible. Once the deductible is met, the appropriate copayment applies.*

Exclusions include, but are not limited to: *custodial care, marital counseling, reversal of sterilization, and care received in an emergency room that is not emergency care. Refer to the Certificate of Coverage for other applicable exclusions and limitations.*

Precertification:

- *Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.*

Pre-existing Exclusion Period:
We will not provide benefits for services, supplies or charges for any pre-existing condition for the time period specified below (subject to HIPAA portability requirements):

12 months after the member's enrollment date

A pre-existing condition is a condition (mental or physical) which was present and for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the member's enrollment date. Pregnancy is not considered a pre-existing condition. Genetic information may not be used as a condition in the absence of a diagnosis.

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

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