Your Summary *of* Benefits

Anthem

Forestadent Usa
Blue Preferred® Select Option 28 with Rx Option AL
Effective 01/01/2019

Covered Benefits	Network	Non-Network
Deductible (Single/Family)	$5,000/$15,000	$10,000/$30,000
Out-of-Pocket Limit (Single/Family)	$5,000/$15,000	$25,000/$75,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician(PCP)/Specialty Care Physician (SCP) Including Office Surgeries and allergy serum: · Allergy injections (PCP and SCP) · Allergy testing · MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds and Pharmaceuticals	$30 / $50 $5 0% 0%	30% 30% 30% 30%
Preventive Care Services Services included but not limited to: Routine medical exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Hearing screenings and Vision screenings which are limited to Screening tests (i.e. Snellen eye chart) and Ocular Photo screening. · Immunizations through age 5	No Cost Share	30% No Cost Share
Emergency and Urgent Care · **Emergency Room Services (facility/other covered services)** *(copayment waived if admitted)* · **Urgent Care Center Services** · MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, Non-Maternity related Ultrasounds and Pharmaceuticals · Allergy injections · Allergy testing	 $300 $50 0% $5 0%	 $300 30% 30% 30% 30%
Inpatient and Outpatient Professional Services Include but are not limited to: · Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams	0%	30%
Inpatient Facility Services Unlimited days except for: · 60 days Network/Non-Network combined for physical medicine / rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) · 90 days Network/Non-Network combined for skilled nursing facility	0%	30%
Outpatient Surgery Hospital / Alternative Care Facility · Surgery and administration of general anesthesia	0%	30%
Other Outpatient Services (including but not limited to): · Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. · Home Care Services (Network/Non-network combined) 100 visits (excludes IV Therapy) · Durable Medical Equipment, Orthotics, and Prosthetics · Physical Medicine Therapy Day Rehabilitation programs · Hospice Care · Ambulance Services	0% No Cost Share 0%	30% No Cost Share 0%

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Covered Benefits	Network	Non-Network
Outpatient Therapy Services		
(Combined Network & Non-Network limits apply)		
· Physician Home and Office Visits (PCP/SCP)	$30 / $50	30%
· Other Outpatient Services @ Hospital/Alternative Care Facility	0%	30%
Limits apply to:		
· Physical / Manipulation therapy excludes Chiropractic Services: 20 visits		
· Occupational therapy: 20 visits		
· Chiropractic Services: 26 visits (Network) Non-Network Not Covered		
· Speech therapy: Unlimited visits		
· Cardiac Rehabilitation: 36 visits		
· Pulmonary Rehabilitation: 20 visits		
· Accidental Dental: $3,000 Limit		
Behavioral Health Services: (Network and Non-Network)		
Mental Health and Substance Abuse		
· Inpatient Facility Services	Benefits provided in accordance with	30%
· Physician Home and Office Visits	Federal Mental Health Parity	30%
· Other Outpatient Facility Services		30%
Human Organ and Tissue Transplants (1)	No Cost Share	30%
· Acquisition and transplant procedures, harvest and storage.		
Prescription Drugs (National):(2)		
Network Tier structure equals 1/2/3 (and 4 and 5 if applicable)		
· **Network Retail Pharmacies:**	$10 / $35 / $60 / 25% $200 max up to	50% , min $60(3)
(30 day supply)	$2,500	
Includes diabetic test strip		
· **Home Delivery**	$10 / $90 / $180 / 25% $200 max up to	Not Covered
(90 day supply)	$2,500	
Includes diabetic test strip		
4th Tier per script max- 30 day supply. Specialty medications are limited to a 30 day supply regardless of whether they are retail or home delivery.		
- Member may be responsible for additional cost when not selecting the available generic drug.		
- Specialty Medications must be obtained via our Specialty Pharmacy network in order to receive network level benefits.		

Notes:

· Flat dollar copayments and Non Network Human Organ and Tissue Transplants are excluded from the out-of-pocket limits. Also Prescription Drug deductibles/copayments/coinsurance are excluded from the out-of-pocket limits.

· Deductible(s) apply only to covered medical services listed with a percentage (%) coinsurance. However, the deductible does not apply to Emergency Room Services where a copayment and a percentage(%) coinsurance applies and may not apply to some Behavioral Health services where coinsurance applies.

· Network and Non-network deductibles, copayments, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other. Network and non-network deductibles are combined for 500 series plans.

· Physical Therapy and Occupational Therapy will take the PCP cost share when performed in the office visit setting.

· Dependent age: to the end of the month in which the child attains age 26.

· Specialist (SCP) copayment is applicable to all Specialists (excludes: General Physicians, Internists, Pediatricians, OB/Gyns, Geriatrics, Physical Therapy, Occupational Therapy or any other Network provider as allowed by the plan).

· When allergy injections are rendered with a Physicians Home and office visit, only the office visit cost share applies.

· No Cost Share means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.

· PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/ gynecology, geriatrics or any other Network provider as allowed by the plan.