Your Summary *of* Benefits

Anthem

CBP MEWA Blue Access® Choice PPO 2500/20%/5500 Plan 7 with Rx Option E59

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Covered Benefits	Network	Non-Network
Deductible (Single/Family) (1)	$2,500 /$7,500	$5,000 /$15,000
Out-of-Pocket Limit (Single/Family) (1)	$5,500/$11,000	$11,000/$33,000
Physician Home and Office Services (PCP/SCP) (2) Primary Care Physician(PCP)/Specialty Care Physician (SCP) Including Office Surgeries: · Allergy injections (PCP and SCP) · Allergy testing · MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies and Pharmaceuticals	$15 / $45 $10 20% 20%	50% 50% 50% 50%
Online Visits (3)	$15	50%
Preventive Care Services (4) 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	50% 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 and Pharmaceuticals · Allergy injections · Allergy testing	 $350/20% $100 20% $10 20%	 $350/20% 50% 50% 50% 50%
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	20%	50%
Inpatient Facility Services (5) 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	20%	50%

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Covered Benefits	Network	Non-Network
Outpatient Surgery Hospital / Alternative Care Facility · Surgery and administration of general anesthesia	20%	50%
Other Outpatient Services (including but not limited to): (6) · 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 · Physical Medicine Therapy Day Rehabilitation programs · Hospice · Ambulance Services	20% See note below for cost share details 20%	50% See note below for cost share details 20%
Outpatient Therapy Services **(Combined Network & Non-Network limits apply)** · Physician Home and Office Visits (PCP/SCP) · Other Outpatient Services @ Hospital/Alternative Care Facility 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 Coverage $3,000 per accident	 $15 / $45 20% See note below for cost share details (2)	 50% 50% Not Covered
Behavioral Health Services: (7) **Mental Health and Substance Abuse** · Inpatient Facility Services · Physician Home and Office Visits · Other Outpatient Facility Services	 Benefits provided in accordance with Federal Mental Health Parity	 50% 50% 50%
Human Organ and Tissue Transplants (8) · Acquisition and transplant procedures, harvest and storage.	No Cost Share	50%
Prescription Drugs (Essential Drug List): (9) **Network Tier structure equals 1/2/3 (and 4 and 5 if applicable)** · **Network Retail Pharmacies:** (30 day supply) Includes diabetic test strip · **Home Delivery** (90 day supply) Includes diabetic test strip Specialty medications are limited to a 30 day supply regardless of whether they are retail or home delivery. - Specialty Medications must be obtained via our Specialty Pharmacy network in order to receive network level benefits. - The Essential formulary is a closed drug list with a focus on therapeutic efficacy and cost effectiveness	 $10 / $35 / $70 / 25% $350 max $25 / $105 / $210 / 25% $350 max	 50% , min $60 Not Covered

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Notes:

(1) Deductible/OOP

All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).

Deductible(s) apply 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 towards each other.

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.

(2) PCP/SCP

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.

SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.

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.

Chiropractic services - 50% Network coinsurance up to the maximum allowable amount and the Deductible applies when Office Visit is Deductible and Coinsurance. Non-network settings not covered.

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

***(3)** LiveHealth Online (www.livehealthonline.com) is the preferred vendor for online visits under this plan.*

***(4)** Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are covered.*

***(5)** Hospital stay for Maternity Coverage will not be limited to less than 48 hours for a vaginal delivery or 96 hours for a caesarean section.*

(6) Other Outpatient Services

DME - 50% coinsurance for Network/Non-Network Durable Medical Equipment, Medical Supplies, Orthotics, Asthma Supplies, and Phenylketonuria (PKU). Excludes Prosthetics, Wigs, Diabetic Supplies and Mastectomy prostheses/etc. which will apply the plan's cost shares (common deductible/ coinsurance). The 50% coinsurance does not apply to the options where network Deductible and the Out of Pocket are the same.

Private Duty Nursing - limited to 82 visits/Calendar Year and 164 visits/lifetime.

Ambulance Non-network non-emergency use limited to $50,000 per occurrence.

***(7)** Behavioral Health: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.*

***(8)** Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.*

(9) RX

If applicable all prescription drug expenses except tier 1, (Network/Non-Network, Retail/Home-delivery combined) apply to the per individual RX deductible. Once the RX deductible is met, the appropriate copayment/coinsurance applies. Also, the Prescription Drug out of pocket maximum applies to Network Retail and Home-delivery combined.

Certain diabetic and asthmatic supplies have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies except diabetic test strips.

Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.

Dependent age: to the end of the month in which the child attains age 26.
Benefit period = Calendar Year

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:** None*

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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.

Authorized group signature (if applicable)	*Date*
Underwriting signature (if applicable)	*Date*