Your summary of benefits

Anthem

Pending NHID Approval

Matthew Thornton Health Plan, Inc./Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Access Blue NE HMO SOS 5000/0%/7150 Rx Tiered 5/25/40/30% 60min 300max/40% 400max 500/ded

Your Network: Access Blue NE HMO

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$5,000 person / $12,000 family	Not covered
Out-of-Pocket Limit	$7,150 person / $14,300 family	Not covered
The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.		
Preventive Care / Screening / Immunization	No charge	Not covered
Doctor Home and Office Services		
Primary Care Visit	$30 copay per visit medical deductible does not apply	Not covered
Preferred Primary Care (PPC)	$5 copay per visit medical deductible does not apply	Not Applicable
Specialist Care Visit	$60 copay per visit medical deductible does not apply	Not covered
Prenatal and Post-natal Care	0% coinsurance after medical deductible is met	Not covered
Other Practitioner Visits:		
Retail Health Clinic	$30 copay per visit medical deductible does not apply	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Live Health On-line Telehealth Visits *Includes Mental Health and Substance Abuse* (*www.livehealthonline.com*)	$5 copay per visit medical deductible does not apply	Not covered
Other Participating Provider On-line Visit *Includes Mental Health and Substance Abuse*	$30 copay per visit medical deductible does not apply	Not covered
Manipulation Therapy	$30 copay per visit medical deductible does not apply	Not covered
Acupuncture *Coverage is limited to 20 visits per benefit period.*	$30 copay per visit medical deductible does not apply	Not covered
Other Services in an Office:		
Allergy Testing	No charge	Not covered
Chemo/Radiation Therapy	$60 copay per visit medical deductible does not apply‡	Not covered
Dialysis/Hemodialysis	0% coinsurance after medical deductible is met	Not covered
Prescription Drugs - *Dispensed in the office*	0% coinsurance after medical deductible is met	Not covered
Diagnostic Services **Lab:**		
Office	No charge	Not covered
Freestanding Lab/Reference Lab	No charge	Not covered
Outpatient Hospital	0% coinsurance after medical deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
X-Ray:		
Office	0% coinsurance after medical deductible is met	Not covered
Freestanding Radiology Center	$125 copay per visit medical deductible does not apply	Not covered
Outpatient Hospital	0% coinsurance after medical deductible is met	Not covered
Advanced Diagnostic Imaging:		
Office	0% coinsurance after medical deductible is met	Not covered
Freestanding Radiology Center	$250 copay per service medical deductible does not apply	Not covered
Outpatient Hospital	0% coinsurance after medical deductible is met	Not covered
Emergency and Urgent Care		
Urgent Care	$100 copay per visit medical deductible does not apply	Covered as In-Network
Urgent Care Doctor and Other Services	0% coinsurance after medical deductible is met	Covered as In-Network
Emergency Room Facility Services *Copay waived if admitted.*	$300 copay per visit after medical deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	0% coinsurance after medical deductible is met	Covered as In-Network
Ambulance	0% coinsurance after medical deductible is met	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	$30 copay per visit medical deductible does not apply	Not covered
Facility Visit:		
Facility Fees	No charge	Not covered
Doctor Services	No charge	Not covered
Outpatient Surgery		
Facility Fees:		
Hospital	0% coinsurance after medical deductible is met	Not covered
Freestanding Surgical Center	$250 copay per visit medical deductible does not apply	Not covered
Doctor and Other Services:		
Hospital	0% coinsurance after medical deductible is met	Not covered
Freestanding Surgical Center	No charge	Not covered
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):		
Facility Fees	0% coinsurance after medical deductible is met	Not covered
Doctor and other services	0% coinsurance after medical deductible is met	Not covered
Recovery & Rehabilitation		
Home Health Care	0% coinsurance after medical deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Rehabilitation services: Office *Coverage for rehabilitative and habilitative physical therapy, occupational therapy and speech therapy is limited to 60 visits combined per benefit period.* Outpatient Hospital *Coverage for rehabilitative and habilitative physical therapy, occupational therapy and speech therapy is limited to 60 visits combined per benefit period.*	$30 copay per visit medical deductible does not apply 0% coinsurance after medical deductible is met	Not covered Not covered
Cardiac rehabilitation Office *Coverage is limited to 36 visits per benefit period.* Outpatient Hospital *Coverage is limited to 36 visits per benefit period.*	$60 copay per visit medical deductible does not apply 0% coinsurance after medical deductible is met	Not covered Not covered
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days per benefit period.*	0% coinsurance after medical deductible is met	Not covered
Hospice	0% coinsurance after medical deductible is met	Not covered
Durable Medical Equipment *Durable Medical Equipment and Prosthetics are subject to a combined in network annual benefit deductible of no more than $100 per member per benefit period.*	20% coinsurance after deductible is met	Not covered
Prosthetic Devices *Durable Medical Equipment and Prosthetics are subject to a combined in network annual benefit deductible of no more than $100 per member per benefit period.*	20% coinsurance after deductible is met	Not covered

Covered Prescription Drug Benefits	Cost if you use a Tier 1 In-Network Provider	Cost if you use a Tier 2 In-Network Provider	Cost if you use an Out-of-Network Provider
Pharmacy Deductible	$500 person / $1,000 family	$500 person / $1,000 family	Not covered

Covered Prescription Drug Benefits	Cost if you use a Tier 1 In-Network Provider	Cost if you use a Tier 2 In-Network Provider	Cost if you use an Out-of-Network Provider
Pharmacy Out of Pocket	Combined with In-Network medical	Combined with In-Network medical	Not covered
Prescription Drug Coverage *Rx Choice Tiered Network w/R90* *Essential Drug List* *This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs.*			
Tier 1a - Typically Lower Cost Generic *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$5 copay per prescription, Pharmacy deductible does not apply (retail) and $13 copay per prescription, Pharmacy deductible does not apply (home delivery)	$10 copay per prescription, Pharmacy deductible does not apply (retail) and Not covered (home delivery)	Not covered (retail and home delivery)
Tier 1b - Typically Generic *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$25 copay per prescription, Pharmacy deductible does not apply (retail) and $63 copay per prescription, Pharmacy deductible does not apply (home delivery)	$35 copay per prescription, Pharmacy deductible does not apply (retail) and Not covered (home delivery)	Not covered (retail and home delivery)
Tier 2 – Typically Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$40 copay per prescription after Pharmacy deductible is met (retail) and $120 copay per prescription after Pharmacy deductible is met (home delivery)	$50 copay per prescription after Pharmacy deductible is met (retail) and Not covered (home delivery)	Not covered (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	Greater of $60 or 30% coinsurance up to $300 per prescription after Pharmacy deductible is met (retail) and Greater of $180 or 30% coinsurance up to $900 per prescription after Pharmacy deductible is met (home delivery)	Greater of $70 or 30% coinsurance up to $400 per prescription after Pharmacy deductible is met (retail) and Not covered (home delivery)	Not covered (retail and home delivery)

Covered Prescription Drug Benefits	Cost if you use a Tier 1 In-Network Provider	Cost if you use a Tier 2 In-Network Provider	Cost if you use an Out-of-Network Provider
Tier 4 - Typically Specialty (brand and generic) *30 day supply (retail pharmacy). 30 day supply (home delivery).*	40% coinsurance up to $400 per prescription after Pharmacy deductible is met (retail and home delivery)	40% coinsurance up to $500 per prescription after Pharmacy deductible is met (retail) and Not covered (home delivery)	Not covered (retail and home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. Adult and children's vision services count towards your out of pocket limit.		
Children's Vision Essential Health Benefits (up to age 19) **Child Vision Deductible**	$0 person	Not Applicable
Vision exam *Limited to 1 exam per benefit period.*	$20 copay	Reimbursed Up to $48
Frames *Limited to 1 unit every 2 benefit periods.*	No charge	Reimbursed Up to $52
Lenses *Limited to 1 unit every 2 benefit periods combined with OON Coverage. OON Reimbursement: Single* Reimbursed Up to $32*, Bifocal* Reimbursed Up to $47*, Trifocal* Reimbursed Up to $66*.*	$20 copay	Receives Reimbursement
Contact Lenses (Elective and Non-Elective) *Limited to 1 unit every 2 benefit periods.*	No charge	Reimbursed Up to $84
Adult Vision (age 19 and older) **Adult Vision Deductible**	$0 person	Not Applicable
Vision exam *Limited to 1 exam per benefit period.*	$20 copay	Reimbursed Up to $48
Frames *Limited to 1 unit every 2 benefit periods.*	$100 Allowance	Reimbursed Up to $52
Lenses *Limited to 1 unit every 2 benefit periods combined with OON Coverage. OON Reimbursement: Single* Reimbursed Up to $32*, Bifocal* Reimbursed Up to $47*, Trifocal* Reimbursed Up to $66*.*	$20 copay	Receives Reimbursement

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Elective Contact Lenses *Limited to 1 unit every 2 benefit periods.*	$100 Allowance	Reimbursed Up to $84
Non-Elective Contact Lenses *Limited to 1 unit every 2 benefit periods.*	No charge	Reimbursed Up to $210

Notes:

- Your medical and prescription copays, coinsurance and deductible count toward your out of pocket amount.
- If you have a visit with your Primary Care Physician, Specialist or Urgent Care at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services" which is generally coinsurance or coinsurance after your deductible is met.
  Costs may also vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- ‡ Your cost share may be reduced when services are provided in a PCP's office.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.

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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.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

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

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (833) 772-4122

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

(TTY/TDD: 711)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (833) 772-4122 .

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (833) 772-4122:

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Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'idiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí łą' bich'į' hadeesdzih ninízingo kojį' hodíilnih (833) 772-4122.

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