

## snapshot of medical coverage available through Anthem

| Covered Benefits  | Network  | Non-Network  |
|---|--|--|
| <b>Deductible</b><br>Family coverage requires the family deductible to be met before coinsurance applies. The single deductible does apply to family coverage.  | Single: \$3,000<br>Family: \$6,000                 | Single: \$7,500<br>Family: \$15,000                  |
| <b>Out-of-Pocket Limit</b>  | Single: \$6,350<br>Family: \$12,700                | Single: \$11,000<br>Family: \$22,000                 |
| <b>Physician Home and Office Services (PCP/SCP)</b><br>Primary Care Physician(PCP)/Specialty Care Physician (SCP)<br>Including Office Surgeries and allergy serum:<br><ul style="list-style-type: none"> <li>Allergy injections (PCP and SCP)</li> <li>Allergy testing</li> <li>MRAs, MRIs, PETS, C-Scans, nuclear cardiology imaging studies, non-maternity related ultrasounds and pharmaceuticals</li> </ul>                       | \$30/\$60<br><br>\$5<br>0%<br>0%                   | 30%<br><br>30%<br>30%<br>30%                         |
| <b>Preventive Care Services</b><br><ul style="list-style-type: none"> <li>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</li> </ul>  | NCS  | 30%  |
| <b>Emergency and Urgent Care</b><br><ul style="list-style-type: none"> <li>Emergency Room Services at Hospital (facility/other covered services)</li> </ul> <b>Urgent Care Center Services</b><br><ul style="list-style-type: none"> <li>MRAs, MRIs, PETS, C-Scans, nuclear cardiology imaging studies</li> <li>Non-maternity related ultrasounds and pharmaceuticals</li> <li>Allergy injections</li> <li>Allergy testing</li> </ul> | \$250<br><br>\$75<br><br>0%<br><br>0%<br>\$5<br>0% | \$250<br><br>30%<br><br>30%<br><br>30%<br>30%<br>30% |
| <b>Inpatient and Outpatient Professional Services</b><br>include but are not limited to:<br><ul style="list-style-type: none"> <li>Medical care visits, intensive medical care, concurrent care, consultations, surgery and administration of general anesthesia and newborn exams</li> </ul>   | 0%   | 0%   |

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|---|---|-----------------|
| <b>Inpatient Facility Services</b> (Network/Non-Network combined) Unlimited days except for: <ul style="list-style-type: none"> <li>• 60 days for physical medicine/rehab (limit includes day rehabilitation therapy services on an outpatient basis)</li> <li>• 100 days for skilled nursing facility</li> </ul>   | 0%  | 30%             |
| <b>Outpatient Surgery Hospital/Alternative Care Facility</b> <ul style="list-style-type: none"> <li>• Surgery and administration of general anesthesia</li> </ul>   | 0%  | 30%             |
| <b>Other Outpatient Services</b> including but not limited to: <ul style="list-style-type: none"> <li>• Non-Surgical Outpatient Services. For example: MRIs, C-Scans, chemotherapy, ultrasounds and other diagnostic outpatient services</li> <li>• Home care services 100 visits (excludes IV therapy) (Network/Non-network combined)</li> <li>• Durable medical equipment, orthotics and prosthetics</li> <li>• Physical medicine therapy day rehabilitation programs</li> <li>• Hospice care</li> <li>• Ambulance services</li> </ul>  | 0%<br>0%  | 30%<br>0%<br>0% |
| <b>Accidental Dental Services</b><br>\$3,000 per accident (Network and Non-network combined)  | Copayments/<br>Coinsurance based on setting where covered services are received | 30%             |
| <b>Outpatient Therapy Services</b> (Combined Network & Non-Network limits apply) <ul style="list-style-type: none"> <li>• Physician home and office visits (PCP/SCP)</li> <li>• Other outpatient services at hospital/alternative care facility</li> </ul> Limits apply to: <ul style="list-style-type: none"> <li>• Cardio rehabilitation: 36 visits</li> <li>• Pulmonary rehabilitation: 20 visits</li> <li>• Physical therapy: 20 visits</li> <li>• Occupational therapy: 20 visits</li> <li>• Speech therapy: 20 visits</li> <li>• Manipulation therapy: 20 visits</li> </ul> | \$30/\$60<br>0%   | 30%<br>30%      |

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|--|---------------------------------------|---------------------------------|
| <b>Behavioral Health Services: Mental Illness and Substance Abuse<sup>1</sup></b> <ul style="list-style-type: none"> <li>• Inpatient facility services</li> <li>• Physician home and office visits (PCP/SPC)</li> <li>• Other outpatient services at hospital/alternative care facility</li> </ul>   | 0%<br>\$30<br>0%                      | 0%<br>\$30<br>0%                |
| <b>Human Organ and Tissue Transplants</b><br>Acquisition and transplant procedures, harvest and storage  | 0%                                    | 30%                             |
| <b>Prescription Drugs</b> <ul style="list-style-type: none"> <li>• Network retail pharmacies: (30-day supply) includes diabetic test strip</li> <li>• Home delivery service: (90-day supply) includes diabetic test strip</li> </ul> - Specialty medications are limited up to a 30 day supply regardless of whether they are retail or mail service<br>- Member may be responsible for additional cost when not selecting the available generic drug. | \$10/\$35/\$60<br><br>\$25/\$87/\$150 | 50% min \$60<br><br>Not covered |

**to find a network provider go to [anthem.com](https://www.anthem.com) or call 1-888-224-4902**

