

# Your summary of benefits



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

Your Plan: Anthem Preferred Blue PPO Alt Net \_HSA 2000/0%/2000

Your Network: Preferred Blue PPO

The annual contribution maximums set by the U.S. Treasury and IRS:

2021

\$3,600 individual coverage

\$7,200 family coverage

(catch up contributions of \$1000 per tax year are allowed for members age 55 and older)

2022

\$ TBD individual coverage

\$ TBD family coverage

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b>	\$2,000 person / \$4,000 family	
<b>Out-of-Pocket Limit</b>	\$2,000 person / \$4,000 family	\$4,000 person / \$8,000 family
<p>The family deductible and out-of-pocket maximum are non-embedded meaning the cost shares of all family members apply to one shared family deductible and one shared family out-of-pocket maximum. The individual deductible and individual out-of-pocket maximum only apply to individuals enrolled under single coverage.</p>		
<b>Preventive Care / Screening / Immunization</b>	No charge	30% coinsurance after deductible is met
<b><u>Doctor Home and Office Services</u></b>		
<b>Primary Care Visit</b>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Specialist Care Visit</b>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Prenatal and Post-natal Care</b>	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b><u>Other Practitioner Visits:</u></b></p> <p>Retail Health Clinic</p> <p>On-line Visit <i>Includes Mental Health and Substance Abuse</i> <a href="http://www.livehealthonline.com">www.livehealthonline.com</a></p> <p><b>Chiropractic/Manipulative Therapy</b> <i>Unlimited</i></p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><b><u>Other Services in an Office:</u></b></p> <p>Allergy Testing</p> <p>Chemo/Radiation Therapy</p> <p>Dialysis/Hemodialysis</p> <p>Prescription Drugs - <i>Dispensed in the office</i></p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><b><u>Diagnostic Services</u></b></p> <p><b>Lab:</b></p> <p>Office</p> <p>Freestanding Lab/Reference Lab</p> <p>Outpatient Hospital</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><b>X-Ray:</b></p> <p>Office</p> <p>Freestanding Radiology Center</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Advanced Diagnostic Imaging:</b> Office  Freestanding Radiology Center  Outpatient Hospital	0% coinsurance after deductible is met  0% coinsurance after deductible is met  0% coinsurance after deductible is met	30% coinsurance after deductible is met  30% coinsurance after deductible is met  30% coinsurance after deductible is met
<u><b>Emergency and Urgent Care</b></u> <b>Urgent Care</b>  <b>Urgent Care Doctor and Other Services</b>	0% coinsurance after deductible is met  0% coinsurance after deductible is met	Covered as In-Network  Covered as In-Network
<b>Emergency Room Facility Services</b>  <b>Emergency Room Doctor and Other Services</b>	0% coinsurance after deductible is met  0% coinsurance after deductible is met	Covered as In-Network  Covered as In-Network
<u><b>Ambulance</b></u>	0% coinsurance after deductible is met	Covered as In-Network
<u><b>Outpatient Mental/Behavioral Health and Substance Abuse</b></u> <b>Doctor Office Visit</b>  <b>Facility Visit:</b> Facility Fees  Doctor Services	0% coinsurance after deductible is met  0% coinsurance after deductible is met  0% coinsurance after deductible is met	30% coinsurance after deductible is met  30% coinsurance after deductible is met  40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b><u>Outpatient Surgery</u></b></p> <p><b>Facility Fees:</b></p> <p>Hospital</p> <p>Freestanding Surgical Center</p> <p><b>Doctor and Other Services:</b></p> <p>Hospital</p> <p>Freestanding Surgical Center</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><b><u>Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):</u></b></p> <p><b>Facility Fees</b>  <i>Coverage for Inpatient Rehabilitation is limited to 60 days and Skilled Nursing services is limited to 100 days per benefit period. Applies to In-Network and Out of Network.</i></p> <p><b>Doctor and other services</b></p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><b><u>Recovery &amp; Rehabilitation</u></b></p> <p><b>Home Health Care</b></p>	<p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p><b>Rehabilitation services:</b></p> <p>Office  <i>Coverage for rehabilitative and habilitative physical therapy, occupational therapy and speech therapy is limited to 60 visits combined per benefit period.</i></p> <p>Outpatient Hospital  <i>Coverage for rehabilitative and habilitative physical therapy, occupational therapy and speech therapy is limited to 60 visits combined per benefit period.</i></p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Cardiac rehabilitation</b> Office <i>Unlimited</i>  Outpatient Hospital <i>Unlimited</i>	0% coinsurance after deductible is met  0% coinsurance after deductible is met	30% coinsurance after deductible is met  30% coinsurance after deductible is met
<b>Skilled Nursing Care (facility)</b> <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 100 days per benefit period.</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Hospice</b>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Durable Medical Equipment</b>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Prosthetic Devices</b>	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<b>Pharmacy Deductible</b>	Combined with In-Network medical deductible	Combined with Non-Network medical deductible
<b>Pharmacy Out of Pocket</b>	Combined with In-Network medical	Combined with Non-Network medical
<b>Prescription Drug Coverage</b> <i>National Drug List</i>		
<b>Tier 1 - Typically Generic</b> <i>30 day supply (retail pharmacy). 90 day supply (home delivery).</i>	0% coinsurance after deductible is met (retail) and Not covered (home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)
<b>Tier 2 – Typically Preferred Brand</b> <i>30 day supply (retail pharmacy). 90 day supply (home delivery).</i>	0% coinsurance after deductible is met (retail) and Not covered (home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)
<b>Tier 3 - Typically Non-Preferred Brand</b> <i>30 day supply (retail pharmacy). 90 day supply (home delivery).</i>	0% coinsurance after deductible is met (retail) and Not covered (home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)

**Notes:**

- Your medical and prescription copays, coinsurance and deductible count toward your out of pocket amount.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under “Outpatient Facility Services”.
- Benefit limited to one hearing aid per ear each time a hearing aid prescription changes or one hearing aid per ear as needed every 5 years, whichever occurs first.
- To view your prescription formulary list log on to [www.anthem.com/health-insurance/customer-care/forms-library](http://www.anthem.com/health-insurance/customer-care/forms-library).
- Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.

*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*

## Language Access Services:

### 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) 814-2566

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) 814-2566.

**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) 814-2566:

**Chinese(中文):** 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(833) 814-2566。

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**French (Français):** Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (833) 814-2566.

**Haitian Creole (Kreyòl Ayisyen):** Si ou gen nempòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (833) 814-2566.

**Italian (Italiano):** In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (833) 814-2566.

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## Language Access Services:

**Korean (한국어):** 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(833) 814-2566로 문의하십시오.

**Navajo (Diné):** Dii naaltsoos biká'ígíí lahgo bina'idiikidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj̄ bee nił hodoonih t'áadoo bááh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih ninízingo koj̄' hodiilnih (833) 814-2566.

**Polish (polski):** W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: (833) 814-2566.

**Punjabi (ਪੰਜਾਬੀ):** ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਬਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (833) 814-2566 ਤੇ ਕਾਲ ਕਰੋ।

**Russian (Русский):** если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (833) 814-2566.

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### It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.