Your summary of benefits

Anthem

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

Your Plan: Anthem Access Blue NE HMO 1500/0%/6450 Rx 3 Tier

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
Deductible	$1,500 person / $3,000 family	Not covered
Out-of-Pocket Limit	$6,450 person / $12,900 family	Not covered
The family out-of-pocket maximum is embedded, meaning the cost shares of one family member will be applied to the per person out-of-pocket maximum; in addition, amounts for all covered family members apply to the family out-of-pocket maximum. No one member will pay more than the per person out-of-pocket maximum. Your copays, coinsurance and deductible count toward your out of pocket amount(s).		
Preventive Care / Screening / Immunization	No charge	Not covered
Virtual Care (Telemedicine / Telehealth Visits) **Virtual Visits - Online visits with Doctors who also provide services in person**		
Primary Care (PCP)	$25 copay per visit	Not covered
Mental Health and Substance Abuse care	$25 copay per visit	Not covered
Specialist	$25 copay per visit	Not covered
Virtual Visits from Online Provider LiveHealth Online *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*		
Primary Care (PCP) and Mental Health and Substance Abuse	$25 copay per visit	Not covered
Specialist Care	$25 copay per visit	Not covered
Visits in an Office		
Primary Care (PCP)	$25 copay per visit	Not covered
Specialist Care	$25 copay per visit	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal) *In-network preventive prenatal and postnatal services are covered at 100%.*	0% coinsurance after medical deductible is met	Not covered
Retail Health Clinic	$25 copay per visit	Not covered
Manipulation Therapy	$25 copay per visit	Not covered
Other Services in an Office		
Allergy Testing	No charge	Not covered
Chemo/Radiation Therapy	$25 copay per visit	Not covered
Dialysis/Hemodialysis	No charge	Not covered
Prescription Drugs *Dispensed in the office*	No charge	Not covered
Surgery	$25 copay per visit	Not covered
Diagnostic Services **Lab**		
Office	No charge	Not covered
Freestanding Lab/Reference Lab	No charge	Not covered
Outpatient Hospital	No charge	Not covered
X-Ray		
Office	No charge	Not covered
Freestanding Radiology Center	No charge	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	No charge	Not covered
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	No charge	Not covered
Freestanding Radiology Center	No charge	Not covered
Outpatient Hospital	No charge	Not covered
Emergency and Urgent Care		
Urgent Care	$50 copay per visit	Covered as In-Network
Urgent Care Doctor and Other Services	No charge	Covered as In-Network
Emergency Room Facility Services *Copay waived if admitted.*	$100 copay per visit	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	Covered as In-Network
Ambulance	No charge	Covered as In-Network
Outpatient Mental Health and Substance Abuse		
Doctor Office Visit	$25 copay per visit	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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Freestanding Surgical Center	0% coinsurance after medical deductible is met	Not covered
Doctor and Other Services		
Hospital	No charge	Not covered
Freestanding Surgical Center	No charge	Not covered
Hospital (Including Maternity, Mental Health and 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	No charge	Not covered
Rehabilitation services *Coverage for rehabilitative and habilitative physical therapy, occupational therapy and speech therapy is limited to 60 visits combined per benefit period.*		
Office	$25 copay per visit	Not covered
Outpatient Hospital	$25 copay per visit	Not covered
Cardiac rehabilitation		
Office	$25 copay per visit	Not covered
Outpatient Hospital	$25 copay per visit	Not covered
Skilled Nursing Care (facility) *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.*	0% coinsurance after medical deductible is met	Not covered
Inpatient Hospice	No charge	Not covered
Durable Medical Equipment	No charge	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prosthetic Devices	No charge	Not covered

Covered Prescription Drug Benefits	Cost if you use a Tier 1 In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible	Not applicable	Not covered
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Not covered
Prescription Drug Coverage *Cost shares for drugs included on the National drug list appear below. Drugs not included on the National drug list will not be covered. Your plan uses the Base Network. You may receive up to a 90-day supply of medication at any retail pharmacy.*		
Tier 1 - Typically Cost Generic *Per 30 day supply (retail pharmacy). Per 90 day supply (home delivery or any retail pharmacy).*	$10 copay per prescription, deductible does not apply (retail) and $20 copay per prescription, deductible does not apply (home delivery)	Not covered (retail and home delivery)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy). Per 90 day supply (home delivery or any retail pharmacy).*	$30 copay per prescription, deductible does not apply (retail) and $60 copay per prescription, deductible does not apply (home delivery)	Not covered (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand/Specialty Drugs *Per 30 day supply (retail pharmacy). Per 90 day supply (home delivery or any retail pharmacy).*	$50 copay per prescription, deductible does not apply (retail) and $100 copay per prescription, deductible does not apply (home delivery)	Not covered (retail and home delivery)

Notes:

- Your plan requires the selection of a Primary Care Physician (PCP). Choosing a PCP is an important decision. Call us at the number on your ID card and we'll help you pick a doctor.
- 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”.
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.

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.

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.

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:

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) 772-4122。

Farsi (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (833) 772-4122 تماس بگیرید.

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) 772-4122.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (833) 772-4122.

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) 772-4122.

Japanese (日本語):この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。 通訳と話すには、(833) 772-4122 にお電話ください。

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(833) 772-4122로 문의하십시오.

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 ła' bich'į' hadeesdzih ninízingo kojį' hodíilnih (833) 772-4122.

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) 772-4122.

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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) 772-4122.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (833) 772-4122.

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