

PLAN BENEFITS GUIDE

NETWORK ONLY. NON-NETWORK SERVICES NOT COVERED.

Calendar-year deductible

Out-of-Pocket Maximum

Physician Office Services

Preventive Care

Well Child Care

NOTE: routine immunizations are covered at 100% through age 5

Diagnostic Services

Inpatient Hospital Services

Outpatient Services

Emergency Room

Urgent Care

Ambulance (includes air)

Maternity Services (dependent daughters are covered)

Outpatient Therapy Services - Maximum visits per benefit period:

- Physical Therapy and Spinal Manipulation - 20 visits maximum
- Speech Therapy - 20 visits maximum
- Occupational Therapy - 20 visits maximum

Mental Health

- Inpatient (Maximum per benefit period - 90 days)
- Outpatient

Substance Abuse (Inpatient and outpatient substance abuse rehabilitation programs are limited to two per lifetime.)

- Inpatient (Maximum per benefit period - 30 days, only covering acute phase of detoxification)
- Outpatient

Home Health Care (Maximum visits per benefit period - 40 visits)

Hospice

Medical Supplies

Durable Medical Equipment/Orthotics (Maximum per benefit period - \$4,000)

Prosthetics (Maximum per benefit period - \$4,000)

Human Organ and Tissue Transplant Services

Lifetime Maximum

HMO PLAN 90

YOU PAY

No deductible

\$3,000 individual / \$9,000 family

\$25 copay, \$5 copay for allergy injections (regular office visit copay applies if any other services are received)

\$25 copay

\$25 copay

\$25 copay in physician's office
10% coinsurance in an outpatient facility

10% coinsurance

10% coinsurance

\$150 copay (waived if admitted as inpatient)

\$50 copay

10% coinsurance

\$25 copay for physician office visit
10% coinsurance for inpatient or outpatient services

\$25 copay in physician's office
10% coinsurance in an outpatient setting

10% coinsurance
\$25 copay

10% coinsurance

\$25 copay (covers diagnosis only)

10% coinsurance

10% coinsurance

10% coinsurance

10% coinsurance

10% coinsurance

10% coinsurance

Unlimited

This Blue Preferred HMO 90 Plan Benefits Guide is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits and exclusions are contained in the contract or certificate of coverage. In the event of a conflict between the contract or certificate of coverage and this Blue Preferred HMO 90 Plan Benefits Guide, the terms of the contract or certificate of coverage will prevail.

PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG BENEFIT OPTION: \$15/\$30/\$60/25%

NETWORK YOU PAY

Retail (30-day supply):

- Tier 1 - \$15 per prescription
- Tier 2 - \$30 per prescription
- Tier 3 - \$60 per prescription
- Tier 4 - 25% per prescription (\$2,500 out-of-pocket maximum)

Mail Service (90-day supply):

- Tier 1 - \$30 per prescription
- Tier 2 - \$75 per prescription
- Tier 3 - \$150 per prescription
- Tier 4 - 25% per prescription (\$2,500 out-of-pocket maximum)

PRESCRIPTION DRUG BENEFIT OPTION: \$15 GENERIC ONLY

NETWORK YOU PAY

Retail (30-day supply):

- Generic Prescription Drugs - \$15 per prescription. Brand-name prescription drugs are not covered. However, you can get discounts on brand-name drugs with your Anthem Blue Cross and Blue Shield ID card.

Mail Service (90-day supply):

- Generic Prescription Drugs - \$30 per prescription. Brand-name prescription drugs are not covered.

Tier 1 - Nearly all Tier 1 drugs are Preferred Generic Prescription Drugs, but tier 1 may also include some lower cost brand-name drugs with the greatest therapeutic value.

Tier 2 - Preferred Brand-Name and/or Generic Drugs that are lower-cost and provide greater therapeutic value than comparable brand-name drugs.

Tier 3 - Nearly all Tier 3 drugs are Brand-Name drugs that cost more or are less efficient than comparable drugs on lower tiers, but Tier 3 may also include some high-cost generic drugs.

Tier 4 - Generally includes self-injectable drugs. The list of Tier 4 Drugs can be found at www.anthem.com or by calling the number on the back of your ID card.

NOTE: If a brand-name drug is purchased when a generic equivalent is available, you are responsible for the difference between the allowed charges for the generic and the brand-name drug, in addition to the generic copay.

Prescription drug benefits administered by WellPoint NextRx, an affiliate of Anthem Blue Cross and Blue Shield. Mail order prescription drug benefits administered by Precision Rx.



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In most of Missouri, Anthem Blue Cross and Blue Shield is the trade name of RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC) and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. Life and disability products are underwritten by Anthem Life Insurance Company (ALIC). RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. Independent licensees of the Blue Cross and Blue Shield Association. © Anthem is a registered trademark. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

