

Your Anthem Benefits



CEBCO Delaware County Blue AccessSM (PPO) Summary of Benefits, Effective 01/01/2010

Covered Benefits	Network	Non-Network
Deductible (Single/Family)	\$100/\$200	\$200/\$400
Out-of-Pocket Limit (Single/Family)	\$1,000/\$2,000	\$2,000/\$4,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/Specialty Care Physician (SCP) Including Office Surgeries and allergy serum: <ul style="list-style-type: none"> allergy injections (PCP and SCP) allergy testing routine and non-routine mammograms (regardless of outpatient setting) diabetic education (regardless of outpatient setting) certain medical nutritional therapy (regardless of outpatient setting) MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies and non-maternity related Ultrasounds 	\$15/\$15 \$5 10% No copayment/coinsurance No copayment/coinsurance No copayment/coinsurance 10%	30% 30% 30% 30% Not Covered 30%
Preventive Care Services Services include but are not limited to: Routine Exams, Pelvic Exams, Pap testing, PSA tests, Immunizations ¹ , Annual diabetic eye exam, Routine Vision and Hearing exams <ul style="list-style-type: none"> Physician Home and Office Visits (PCP/SCP) Other Outpatient Services @ Hospital/Alternative Care Facility 	No copayment/coinsurance No copayment/coinsurance	30% 30%
Emergency and Urgent Care <ul style="list-style-type: none"> Emergency Room Services @ Hospital (facility/other covered services) (copayment waived if admitted) Urgent Care Center Services 	\$75 \$35	\$75 \$35
Inpatient and Outpatient Professional Services Include but are not limited to: <ul style="list-style-type: none"> Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams 	10%	30%
Inpatient Facility Services Unlimited days except for: <ul style="list-style-type: none"> 60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) 90 days Network/Non-Network combined for skilled nursing facility 	10%	30%
Outpatient Surgery Hospital/Alternative Care Facility <ul style="list-style-type: none"> Surgery and administration of general anesthesia 	10%	30%
Other Outpatient Services (including but not limited to): <ul style="list-style-type: none"> Non Surgical Outpatient Services for example: MRIs, C-Scans, Chemotherapy, Ultrasounds, and other diagnostic outpatient services. Home Care Services (Network/Non-network combined) 90 visits (excludes IV Therapy) Durable Medical Equipment and Orthotics (Network/ Non-network combined) \$10,000 benefit maximum (excluding Prosthetic Devices and Medical Supplies) Prosthetic Devices \$10,000 benefit maximum Physical Medicine Therapy Day Rehabilitation programs Hospice Care Ambulance Services 	10% 20% 20%	30% 20% 20%

Covered Benefits	Network	Non-Network
Outpatient Therapy Services (Combined Network & Non-Network limits apply) <ul style="list-style-type: none"> Physician Home and Office Visits (PCP/SCP) Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: <ul style="list-style-type: none"> Physical therapy: 30 visits Occupational therapy: 30 visits Manipulation therapy: 12 visits Speech therapy: 20 visits 	\$15/\$15 10%	30% 30%
Behavioral Health Services: Mental Health and Substance Abuse (2) <ul style="list-style-type: none"> Inpatient Facility Services Physician Home and Office Visits (PCP/SCP) Other Outpatient Services @ Hospital/Alternative Care Facility 	10% \$15/\$15 10%	30% 30% 30%
Human Organ and Tissue Transplants³ <ul style="list-style-type: none"> Acquisition and transplant procedures, harvest and storage. 	No copayment/coinsurance	50%
Prescription Drugs Network Tier structure equals 1/2/3 (and 4, if applicable) <ul style="list-style-type: none"> Network Retail Pharmacies: (30-day supply) Includes diabetic test strip Anthem Rx Direct Mail Service: (90-day supply) Includes diabetic test strip Medicare Rx - Wrap	Covered under separate plan	Covered under separate plan
Lifetime Maximum (Combined Network and Non-network)	\$5 million	\$5 million

Notes:

- Flat dollar copayments are excluded from the out-of-pocket limits. Also Prescription Drug deductibles/copayments/coinsurance and Non-network Human Organ and Tissue Transplants are excluded from the out-of-pocket limits.
- Deductible(s) apply only to covered medical services listed with a percentage (%) coinsurance. However, the deductible does not apply to Emergency Room Services @ Hospital where a percentage (%) coinsurance applies to other covered services.
- Network and Non-network deductibles, copayments, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- Dependent Age: to the end of the calendar year which the child attains age 19; or to the end of the calendar year which the child attains age 25 if the child qualifies as a full-time student.
- Specialist copayment is applicable to all Specialists excluding General Physicians, Internist, Pediatricians, OB/GYN's and Geriatrics or any other Network Provider as allowed by the plan.
- Physicians Home and office visit copayment also applies if the office visit is billed with allergy injections.
- No copayment/coinsurance means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan.
- SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
- Certain diabetic and asthmatic supplies have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies except diabetic test strips.
- Benefit period = calendar year

¹These covered services are not subject to the deductible/copayment if you have a flat dollar copayment and if rendered without an office visit.

²We encourage you to contact Our Mental Health Subcontractor to assure the use of appropriate procedures, setting and medical necessity.

³Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.

Precertification:

- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help avoid any unnecessary reduction in benefits or non-covered or non-medically necessary services.

Pre-existing Exclusion Period:

We will not provide benefits for services, supplies or charges for any pre-existing condition for the time period specified below (subject to HIPAA portability requirements):
 12 months after the member's enrollment date

A pre-existing condition is a condition (mental or physical) which was present and for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the member's enrollment date. Pregnancy and domestic violence are not considered a pre-existing condition. Genetic information may not be used as a condition in the absence of a diagnosis.

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.

Deductions are based on 24 pays per year:

Single coverage: \$ 7.18 per pay

Family coverage: \$18.10 per pay