

# 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<sup>®</sup> 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 [anthem.com](http://anthem.com) or by calling the number on the back of your ID card.

#### Specialty Drugs

Specialty Drugs are high cost, scientifically engineered drugs. They are usually injected or infused and require special storage and handling that make them difficult for a typical pharmacy to dispense. Specialty Drugs must be obtained through our Specialty Pharmacy network in order to receive network level benefits.

**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.

**Note:** You will be responsible for only one Copayment/Coinsurance for a covered Prescription Drug if the required single dosage is unavailable and/or a combination of dosage amounts is needed to fill the Prescription Order.

Mail order and prescription drug benefits administered by WellPoint NextRx.

In most of Missouri: Anthem Blue Cross and Blue Shield is the trade name for 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. 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.

## **And now – some really important legal information you should take the time to read.**

### **Who can apply.**

You can apply for Blue Preferred® HMO 90 coverage for yourself or with your family. Family health coverage includes you, your spouse and any dependent children. Children are covered to the end of the month in which they turn 25. You must be under age 65, live in our service area, not be covered by any other group or individual health plan and meet our underwriting guidelines.

### **The Blue Preferred HMO 90 Plan covers preexisting conditions.**

#### **What we do not cover.**

Blue Preferred HMO 90 plans don't provide benefits for non-network coverage; private duty nursing; experimental or investigative treatment; dental and vision, except as spelled out in your Contract; charges greater than the maximum allowable amount (charges exceeding the amount Anthem recognizes for services); care provided by a member of your family; treatment that's primarily intended to improve your appearance; weight loss programs or treatment of obesity; hearing aids, except as explained in your Contract; eyeglasses or contact lenses; radial keratotomy or keratomileusis or excimer laser photo; artificial insemination, fertilization, infertility drugs or sterilization reversal; sex transformation surgery; custodial care; artificial and mechanical hearts; workers' compensation; and services we determine aren't medically necessary.

These are some of the exclusions contained in the plans. Check your contract or certificate of coverage for a complete listing of benefits, exclusions and maximum payment levels. For more information on the grievance and external review rights, please review your contract or certificate of coverage.

#### **Our appeal rights and confidentiality policy.**

If we deny a claim or request for benefits completely or partially, we will notify you in writing. The notice will explain why we denied the claim/request and describe the appeals process. You can appeal decisions that deny or reduce benefits. We encourage you to file appeals right away when you first get an initial decision from us, but we require that you file within six months of getting one. You should send additional information that supports your appeal and state all the reasons why you feel the appeal request should be granted. We will review your appeal and let you know our decision in writing within 30 days of receiving your first appeal. If you remain dissatisfied with the response to the first review, you may submit any additional information, including written comments, records or documents that you want us to consider in a second level appeal.

If you are denied coverage based on medical necessity or experimental/investigative exclusions, you can request that a board-eligible or board-certified specialist review your appeal. If we deny coverage for reasons other than medical necessity or experimental/investigative reasons, you can also appeal.

Please call customer service or check your Contract for more information on our internal appeal and external review processes. Unless our notice of decision includes a different address, send requests for a review of appeal to:

**Anthem Blue Cross and Blue Shield  
Grievance and Appeals  
P.O. Box 14882  
St. Louis, MO 63178-4882**

If we uphold our decision throughout the appeals process, you at any time can request a review by the Missouri Department of Insurance. In addition to the appeals processes we just described, Anthem has adopted a Confidentiality Policy in Missouri. This policy includes guidelines regarding the protection of confidential member information and a member's right to access and change information in Anthem's possession. The policy clearly points out when a member needs to sign a release before Anthem can disclose information to a member's provider, spouse or other family members.

## **We want you to be satisfied.**

If you aren't satisfied with your Blue Preferred HMO 90 coverage, you can cancel it within 30 days after you receive your Contract or have access to it online, whichever is earlier. If you haven't submitted any claims, you'll get a full refund of the premium you paid when coverage is cancelled within the first 30 days. You can view your Contract online or receive a paper copy of it upon request as outlined in your initial membership letter.

## **Information about our Network Providers.**

### **Using our network.**

To be eligible to receive benefits, you must use network providers. (Please refer to your provider directory, located on [anthem.com](http://anthem.com), for a list of network providers.)

### **Notice of provider arrangements.**

Your network provider's agreement for providing covered services may include financial incentives or risk-sharing relationships that are based on utilization and quality of services. If you have any questions regarding such incentives or risk-sharing relationships, please contact Anthem or your provider.

## Accessing Covered Services.

Some services, or supplies, such as prescription drugs, require your doctor to receive an authorization from Anthem that defines and/or limits the conditions under which the service, or supply, will be covered to help you avoid any unnecessary out-of-pocket expenses. Other services, such as organ transplants, require your physician to certify, and for us to approve the service as medically necessary and the appropriate setting. Neither process is a guarantee of coverage.

## Non-network provider.

If you receive covered services from a non-network provider, you are responsible for the entire charge, except for emergency care and ambulance services.

## Some definitions—so we're all on the same page.

A **premium** is the amount of money you pay on a regular basis—once a month, four times a year, twice a year or once a year—to your insurance company to keep your health plan active.

A **copayment** is a specific dollar amount of the maximum allowable amount for covered services which you pay. The copayment does not apply to any coinsurance that you are required to pay.

A **coinsurance level** is the percentage of money you have to pay out of your own pocket for covered services.

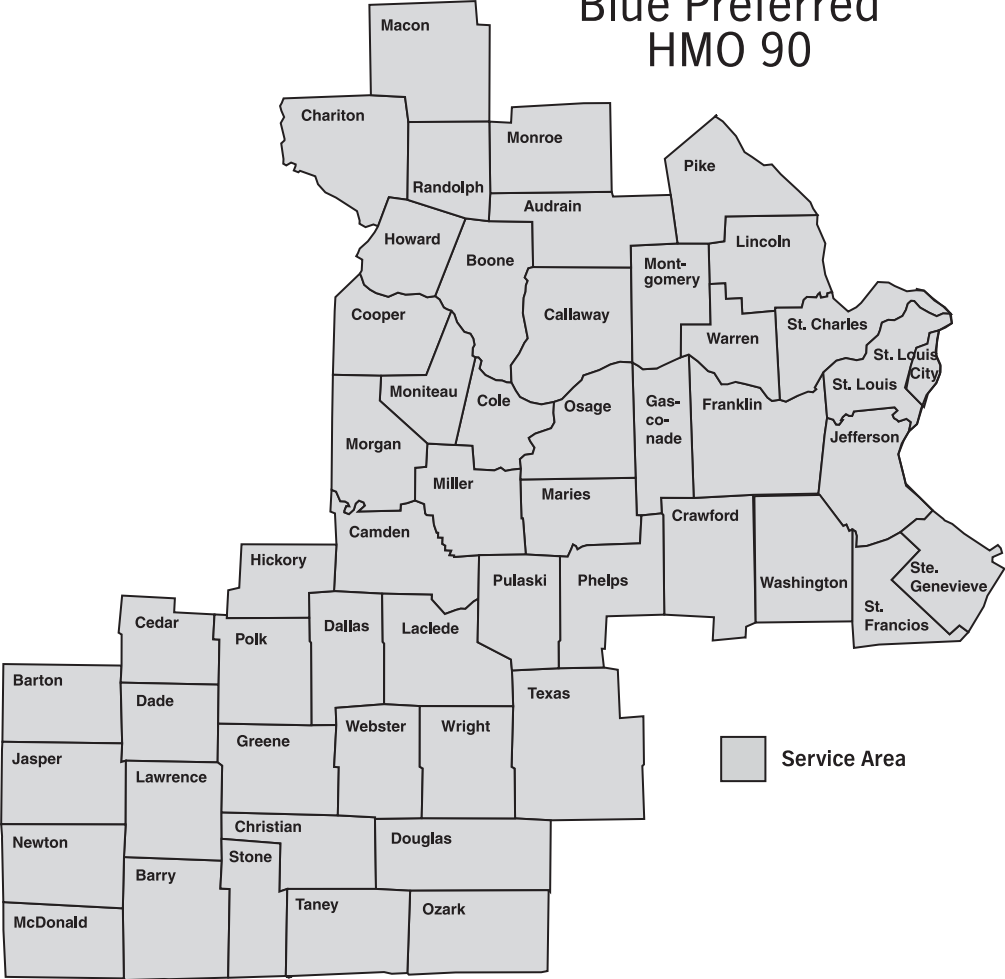
An **out-of-pocket limit** is the total amount of money (not counting your premiums) you have to pay each year for your healthcare coverage. Your coinsurance payments for covered services count toward your out-of-pocket limit.

A **discount** is the reduced out-of-pocket cost you enjoy when you obtain healthcare services from a network provider.

A **drug formulary** is a list of brand-name and generic medications that have been rigorously reviewed and selected by a committee of practicing doctors and clinical pharmacists for their quality and effectiveness. You may help control the amount you pay for prescriptions by discussing with your doctor whether you can use medications from the Anthem formulary on our website at [anthem.com](http://anthem.com).

# Service Area Map

Blue Preferred<sup>®</sup>  
HMO 90



For More Information, Call Our  
Sales Department at 1-888-877-9125.



In most of Missouri: Anthem Blue Cross and Blue Shield is the trade name for RightCHOICE<sup>®</sup> Managed Care, Inc. (RIT), Healthy Alliance<sup>®</sup> 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. 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.