Your Summary of Benefits

Anthem

Trends International, LLC
Blue Access® for Health Savings Accounts Option #2 Rx Option 5
Effective January 1, 2015

PLAN 1

Covered Benefits	Network	Non-Network
Deductible Family coverage requires the family deductible to be met before coinsurance applies. The single deductible does not apply to family coverage.	Single: $2,000 Family: $4,000	Single: $4,000 Family: $8,000
Out-of-Pocket Limit	Single: $3,000 Family: $6,000	Single: $8,000 Family: $16,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/ Specialty Care Physician (SCP) Including Office Surgeries and allergy serum: • allergy injections (PCP and SCP) • allergy testing • MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, and pharmaceutical products	0% 0% 0% 0%	30%
Preventive Care Services Services included but not limited to: • Routine medical exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Hearing screenings and Vision screenings which are limited to Screening tests (i.e. Snellen eye chart) and Ocular Photo screening	NCS	30%
Emergency and Urgent Care • **Emergency Room Services (facility/other covered services)** (copayment waived if admitted) • **Urgent Care Center Services**	0% 0%	0% 30%
Inpatient and Outpatient Professional Services Include but are not limited to: • Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams	0%	30%
Inpatient Facility Services (Network/Non-Network combined) Unlimited days except for: • 60 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) • 90 days for skilled nursing facility	0%	30%

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Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	0%	30%
Other Outpatient Services (Network/Non-network combined) including but not limited to: • Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. • Home Care Services 100 visits (excludes IV Therapy) • Durable Medical Equipment and Orthotics • Prosthetic Devices • Prosthetic Limbs • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	0% 0% 0%	30% 0% 0%
Accidental Dental Services $3,000 limit per occurrence (Network and Non-network combined)	0%	30%
Outpatient Therapy Services (Combined Network & Non-Network limits apply) • Physician Home and Office Visits • Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: • Physical therapy: 20 visits • Occupational therapy: 20 visits • Manipulation therapy: 12 visits • Speech therapy: 20 visits • Cardiac Rehabilitation: 36 visits • Pulmonary Rehabilitation: 20 visits	 0% 0%	 30% 30%
Behavioral Health Service **Mental Illness and Substance Abuse[1]:** • Inpatient Facility Services • Inpatient Professional Services • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services, Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional.	0%	30%
Human Organ and Tissue Transplants • Acquisition and transplant procedures, harvest and storage.	0%	30%

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Prescription Drugs • **Network Retail Pharmacies:** (30-day supply) Includes diabetic test strip • **Home Delivery Service:** (90-day supply) Includes diabetic test strip Specialty medications are limited up to a 30 day supply regardless of whether they are retail or mail service. Medicare Rx - Wrap	Medical deductible applies before copayments. $10/$30/$60/25% w $200 maximum. $10/$75/$180/25% w $200 maximum.	50%[2] min $60[2] Not covered
Lifetime Maximum	Unlimited	Unlimited

Notes:

- **All deductibles and coinsurance apply toward the out-of-pocket maximum including prescription drugs. (Excludes Non-network Human Organ and Tissue Transplants).**
- **Deductible(s) apply to covered services listed with a percentage (%) coinsurance including 0%.**
- **Deductible applies to all prescription drug expenses. Once the deductible is met the appropriate copayment/coinsurance applies.**
- **Network and non-network deductibles, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.**
- **Dependent Age: to end of the month which the child attains age 26**
- **No cost share (NCS) means no deductible/copayment/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.**
- **Benefit period = calendar year**
- **Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.**
- **Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are covered.**
- **Private Duty Nursing – limited to 82 visits/Calendar Year and 164 visits/lifetime.**
- **Elective abortions not covered unless otherwise noted in your Certificate of Coverage.**

2 We encourage you to review the Schedule of Benefits for limitations.
3 Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.
4 Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.

Precertification:
Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.