

Medicare Covers	Medicare Pays	DCMS Covered Services	Your Share of the Cost
<p>Physician's Services</p>	<p>80% of Medicare approved charges after \$135 annual deductible</p>	<p>Physician's Services</p> <ul style="list-style-type: none"> • Home and office visits • Surgery • Assisting surgeon • Anesthesia • X-ray & laboratory tests • Inhospital medical care • Consultations • Radiologist services • Maternity care • Chiropractic visits 	<p style="text-align: center;">Subject to:</p> <p>\$250 deductible per member per calendar year and then 20% coinsurance up to an out of pocket maximum of \$450 for medical services per calendar year.</p> <p>\$900 out of pocket maximum per member per calendar year for medical (\$450) and prescription drug (\$450)</p>
<p>Hospital Services <i>Inpatient Benefits</i></p> <p>First 60 days of Medicare benefit period</p> <p>Next 30 days (61st through 90th days)</p> <p>Next 60 days of one-time lifetime reserve days (91st through 150th days)</p> <p>After 150 days of continuous confinement</p> <p>Outpatient Benefits</p> <p>Skilled Nursing Home Benefits First 20 days of benefit period</p> <p>Next 80 days</p> <p>After 100 days of continuous confinement</p>	<p>Full cost after \$1068 deductible</p> <p>\$267 co-insurance per day</p> <p>\$534 co-insurance per day</p> <p>Nothing</p> <p>80% of Medicare approved charges after (rate) annual deductible</p> <p>Full cost</p> <p>\$133.50 co-insurance</p> <p>nothing</p>	<p>Hospital Services <i>Inpatient Benefits</i></p> <ul style="list-style-type: none"> • Semiprivate room and board (including Intensive Care Unit) • Operating, treatment and recovery rooms • Medications, drugs and solutions • X-ray & lab tests • Radiation therapy <p><i>Outpatient Benefits</i></p> <ul style="list-style-type: none"> • Emergency & operating rooms • X-ray & laboratory tests • Radiation therapy <p>Skilled Nursing Facility Physical Rehabilitation Facility</p>	
<p>Mental Health Services</p> <p>Inpatient Psychiatric Services</p> <p>Non Inpatient Psychiatric Services</p>	<p>Cost sharing same as above for inpatient hospital services - 190 day lifetime limit</p> <p>80% of Medicare approved charges after psychiatric reduction</p>	<p>Mental Health Services</p> <ul style="list-style-type: none"> • Office visits • Inpatient care • Partial hospitalization • Outpatient care such as therapeutic services and diagnostic tests 	
<p>Other Services and Supplies</p> <p>Durable Medical Equipment, Ambulance Services, Prosthetics, Physical and Occupational Therapy,</p> <p>Home Health</p> <p>Private Duty Nursing</p>	<p>80% of Medicare approved charges after \$135 annual deductible</p> <p>Full cost</p> <p>Nothing</p>	<p>Other Services & Supplies</p> <ul style="list-style-type: none"> • Durable medical equipment • Emergency ambulance transportation • Prosthetics • Physical and occupational therapy • Home Health Agency services) • Private duty nursing 	

PRESCRIPTION DRUGS

Covered medications purchased at a retail pharmacy

30% coinsurance per member per calendar year up to an out of pocket maximum of \$450 per calendar year

Exclusions and Limitations

This is a partial list of services that are not covered by this plan. Please review your Subscriber Certificate for complete details on exclusions and limitations

Services Not Covered

• Any service that is not medically necessary • Any service required by a third party (court ordered services are covered if all of the other terms of the plan are met) • Artificial insemination, assisted reproduction technologies and infertility treatments • Claims for services received more than 12 months ago • Complementary and Alternative Therapies/Medicine • Cosmetic surgery • Custodial or convalescent care • Educational testing and therapy • Experimental and/or investigational services • Hospitalization related to conditions that are not covered • Human organ transplants other than those listed in the subscriber certificate as covered benefits • Mental health services which do not usually result in favorable modification through short-term therapy • Miscellaneous devices, materials, and supplies, including, but not limited to hearing aids, eyeglasses, contact lenses (except after cataract surgery), dentures and support devices for the feet and corrective shoes • Personal comfort items • Radial keratotomy or other surgery to correct vision • Routine podiatry • Services covered by government programs to the extent permitted by law • Services for work-related illness or injury • Sex changes • Weight reduction management and control except diabetes education and nutritional counseling.

Anthem Blue Cross and Blue Shield has the right to recover its costs for care of:

• Injuries which are the responsibility of other parties • Services for which we pay benefits in error • Services related to illegal conduct

This is only a brief summary of your coverage.

Benefits apply when care is **medically necessary**. Services are covered up to the Maximum Allowable Benefit (MAB). Participating providers agree to accept the MAB as payment in full. However, if you receive services from a non-participating provider, it is your responsibility to pay the difference between the MAB and the provider's charge.

This summary of benefits is not a contract. It is a general description of the benefits and exclusions of this plan. Pre-existing condition limitations apply. Complete information about all benefits, limitations and exclusions is in the Subscriber Certificate, which will be mailed to you after you enroll. If you need further information, call Customer Service at 1-800-437-9282.