

Your Summary of Benefits



Technology Consulting Inc
Blue Access® Option 12 with Rx Option H
Effective 04/01/2011

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Covered Benefits	Network	Non-Network
Deductible (Single/Family)	\$1,500/\$4,500	\$3,000/\$9,000
Out-of-Pocket Limit (Single/Family)	\$3,000/\$6,000	\$6,000/\$12,000
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 Pharmaceuticals	\$20/\$50 \$5 20% 20%	40% 40% 40% 40%
Preventive Care Services Services include but are not limited to: Routine Exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations(1), Annual diabetic eye exam, Routine Vision and Hearing screenings	No Copayment/Coinsurance	40%
Emergency and Urgent Care · Emergency Room Services @Hospital (facility/other covered services) (copayment waived if admitted) · Urgent Care Center Services · MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, Non-Maternity related Ultrasounds and Pharmaceuticals · Allergy injections · Allergy testing	\$200/20% \$75 20% \$5 20%	\$200/20% 40% 40% 40% 40%
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	20%	40%
Inpatient Facility Services Unlimited days except for: · 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	20%	40%
Outpatient Surgery Hospital / Alternative Care Facility · Surgery and administration of general anesthesia	20%	40%
Other Outpatient Services (including but not limited to): · 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, Orthotics, and Prosthetics · Physical Medicine Therapy Day Rehabilitation programs · Hospice Care · Ambulance Services	20% No Copayment/Coinsurance 20%	40% No Copayment/Coinsurance 20%

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Covered Benefits	Network	Non-Network
Outpatient Therapy Services (Combined Network & Non-Network limits apply) • Physician Home and Office Visits (PCP/SCP) • 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 • Accidental Dental: \$3,000 Limit	\$20/\$50 20%	40% 40%
Behavioral Health Services: Mental Health and Substance Abuse (2) (limits and maximums apply) • Inpatient Facility Services • Physician Home and Office Visits • Other Outpatient Services @ Hospital/Alternative Care Facility Inpatient: 30 Network days Outpatient: 30 Network visits Substance Abuse (non-network) Non-Network limits apply (Substance abuse rehabilitation programs are limited to two per lifetime Network and Non-Network combined.)	20% \$50 20%	40% (Inpatient mental health not covered) 40% 40%
Human Organ and Tissue Transplants(3) • Acquisition and transplant procedures, harvest and storage.	No Copayment/Coinsurance	50%
Prescription Drugs:(4) Network Tier structure equals 1/2/3 (and 4 if applicable) • Network Retail Pharmacies: (30 day supply) Includes diabetic test strip • Anthem Mail Service: (90 day supply) Includes diabetic test strip - *4th Tier per script max-\$150 30 day supply. Specialty medications are limited to a 30 day supply regardless of whether they are retail or mail service. - Member may be responsible for additional cost when not selecting the available generic drug. - Specialty Medications must be obtained via our Specialty Pharmacy network in order to receive network level benefits.	\$10 / \$40 / \$60 / 25% \$150 max* up to \$2,500 out of pocket maximum \$10 / \$100 / \$180 / 25% \$150 max* up to \$2,500 out of pocket maximum	50% , min \$60(5) Not Covered

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 to covered medical services listed with a percentage (%) coinsurance (excluding Emergency Room Services @ Hospital)
- 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 month in which the child attains age 26.
- 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.
- When allergy injections are rendered with a Physicians Home and office visit, only the office visit cost share applies.
- No copayment/coinsurance 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.

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