Your Summary of Benefits

Anthem BlueCross BlueShield

Scott County School District #2
Anthem Blue Access® PPO Health Savings Accounts Option E1 with Rx Option C2
Effective January 1, 2019

Covered Benefits	Network	Non-Network
Deductible Embedded The single deductible applies to the Family deductible. Once the single deductible has been satisfied, benefits for that member are payable subject to coinsurance. Once the family deductible has been satisfied, benefits for the family are payable subject to coinsurance.	Single: $2,700 Family: $5,400	Single: $5,400 Family: $10,800
Out-of-Pocket Limit	Single: $3,700 Family: $7,400	Single: $10,800 Family: $21,600
Physician Home and Office Services • Including Office Surgeries, allergy serum, allergy injections and allergy testing	0%	30%
Preventive Care Services • 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	No cost share	30%
Emergency and Urgent Care • Emergency Room Services (facility/other covered services) (copayment waived if admitted) • Urgent Care Center Services	0% 0%	Same As in-network 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%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	0%	30%
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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 100 visits (excludes IV Therapy) (Network/Non-Network combined) Durable Medical Equipment • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	0% 0% 0%	30% 0% 0%
Accidental Dental Services $3,000 per accident (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 Physical Medicine Therapy Limits, Outpatient Therapy (Network and Non-network combined): • Cardiac Rehabilitation 36 visits • Pulmonary Rehabilitation 20 visits • Physical Therapy: 20 visits • Occupational Therapy: 20 visits • Manipulation Therapy: 12 visits • Speech Therapy: 20 visits	 0% 0%	 30% 30%
Behavioral Health Service Mental Illness and Substance Abuse[1]: • Inpatient Facility Services • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services, Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional.	0% 0% 0% 0%	30%
Human Organ and Tissue Transplants • Acquisition and transplant procedures, harvest and storage.	0%	30%

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Prescription Drugs Essential Formulary* Network Tier structure equals 1/2/3 (and 4/5, if applicable)		
• Network Retail Pharmacies: (30-day supply) Includes diabetic test strip	$10/$35/$75/25% w $350 max	50%[2]
• Home Delivery Service: (90-day supply) Includes diabetic test strip	$25/$105/$225/25% w $350 ma	Not covered
Members have additional cost with retail supply greater than 30 days. Specialty medications are limited up to a 30 day supply regardless of whether they are retail or mail service. Medicare Rx - Wrap		

Notes:

- All medical and drug cost shares, deductibles and percentage (%) coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).
- Deductible(s) apply to covered services listed with a percentage (%) coinsurance, including 0%.
- Deductible applies to all prescription drug expenses for Rx plans. Once the deductible is met the appropriate copayment/ coinsurance applies. Copayments/coinsurance accumulate to the Medical OOP max. Once the Medical OOP max is met, no additional cost share applies.
- Once the family deductible is satisfied by either one member or all members collectively, then the additional percentage coinsurance will be required before the family out-of-pocket is satisfied. Does not apply to embedded deductible plans.
- Network and Non-network Deductible, copayments, 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
- 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.
- No Cost Share (NCS): No deductible/copayment/coinsurance up to the maximum allowable amount.
- Ambulance Non-network non-emergency use limited to $50,000 per benefit period.
- Live Health Online (LHO) is covered at the PCP cost share.
- 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.
- Prosthetics Limbs are unlimited and do not apply to the Plan Lifetime Maximum.[4]
- 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.
- Wigs limited to 1 per benefit period

[1] We encourage you to review the Schedule of Benefits for limitations.
[2] Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.

The Rx option includes the Essential formulary which is a closed drug list with a focus on therapeutic efficacy and cost effectiveness.

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.

Pre-existing Exclusion Period: None

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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.

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.