Your Summary of Benefits

Anthem BlueCross BlueShield

Scott County School District 2
Anthem Blue Access® PPO Health Savings Accounts
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: $4,000 Family: $8,000	Single: $8,000 Family: $16,000
Out-of-Pocket Limit	Single: $5,000 Family: $10,000	Single: $16,000 Family: $32,000
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	$30/$50 $10 0% 0%	30% 30% 30% 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** • MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, • Non-Maternity related Ultrasounds and Pharmaceuticals • Allergy injections • Allergy testing	$250 $75 0% $10 0%	$250 30% 30% 30% 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%
Blue 11		

Your Summary of Benefits

Covered Benefits	Network	Non-Network
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%
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% 0% 0%	30% 30% 30% Same as in-network Same as in-network
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): • Cardio Rehabilitation: 36 visits • Pulmonary Rehabilitation: 20 visits • Physical therapy: 20 visits • Occupational therapy: 20 visits • Speech therapy: 20 visits • Manipulation therapy: 12 visits	 $30/$50 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% $30/after ded 0%	 30% 30% 30%
Human Organ and Tissue Transplants • Acquisition and transplant procedures, harvest and storage.	0%	30%

Your Summary of Benefits

Covered Benefits	Network	Non-Network
Prescription Drug Options: Anthem National Drug List Network Tier structure equals 1/2/3 (and 4/5, if applicable) • **Network Retail Pharmacies:** (30-day supply) Includes diabetic test strip • **Home Delivery Service:** (90-day supply) Includes diabetic test strip Member may be responsible for additional cost when not selecting the available generic drug. Members have additional cost with retail supply greater than 30 days. Medicare Rx - Wrap **Specialty Medications** must be obtained via our Specialty Pharmacy network in order to receive network level benefits Specialty medications are limited to 30 day supply regardless of whether they are retail or mail order.	$10/$30/$60/25% w $250 Max $20/$90/$180/25% w $250 Max	50%[2] Not covered

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 all covered medical services and prescription drug services excluding Network Preventive Care services. Then the appropriate copay/coinsurance may apply.
- Network and non-network deductibles, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- 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.
- When allergy injections are rendered with a Physicians Home and Office Visit, only the Office Visit cost share applies. When the Office Visit cost share is a % coinsurance, deductible and coinsurance apply to allergy injections
- PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan.
- SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
- No Cost Share (NCS): No deductible/copayment/coinsurance up to the maximum allowable amount.
- Hospital stay for Maternity coverage will not be limited to less than 48 hours for a vaginal delivery or 96 hours for a caesarean section.
- Ambulance Non-network non-emergency use limited to $50,000 per benefit period.
- Live Health Online (LHO) is covered at the PCP costshare.
- 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.
- Certain diabetic and asthmatic supplies including test strips are covered subject to medical deductible and then any applicable Prescription Drug Copayments/Coinsurance when obtained from a Network Pharmacy.
- 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.

[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.

Your Summary of Benefits

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

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.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature (if applicable)	Date 10/29/18
Underwriting signature (if applicable)	Date