Your Summary of Benefits

Anthem BlueCross BlueShield

Shawnee State University
Anthem Blue Access®-OH I Options PPO for Health Savings Accounts and National Rx Formulary
Networks Tier 1/2: Blue Access® -OH I
Effective 01/01/2019

Covered Benefits	Network Tier 1	Network Tier 2	Non-Network Tier 3
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: $3,000 Family: $6,000	Combined with Tier 1	Single: $6,000 Family: $12,000
Out-of-Pocket Limit (Single/Family)	Single: $6,000 Family: $12,000	Combined with Tier 1	Single: $12,000 Family: $24,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/ Specialty Care Physician (SCP) Including Office Surgeries and allergy serum: o allergy injections (PCP and SCP) o allergy testing o MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, and pharmaceutical products	10% $5 10% 10%	20% $5 20% 20%	40% 40% 40% 40%
Preventive Care Services Services included but not limited to: o 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	No Cost Share	40%
Emergency and Urgent Care **Emergency Room Services** o **facility/other covered services** (copayment waived if admitted) **Urgent Care Center Services** o MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, and pharmaceutical products o Allergy injections o Allergy testing	 Deductible then $75 10% 10% $5 10%	 Deductible then $75 10% 10% $5 10%	 40% 40% 40% 40% 40%

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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	10%	20%	40%
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) • 100 days for skilled nursing facility	10%	20%	40%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	10%	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 100 visits (excludes IV Therapy) (Network/Non-Network combined) • Durable Medical Equipment • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	10% 10% 10% 10%	20% 20%. 10% 10%	40% 40% 10% 10%
Outpatient Therapy Services (Combined Network & Non-Network limits apply) • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility Physical Medicine Therapy Limits, Outpatient Therapy (excludes Autism Spectrum Disorder)- (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	 10% 10%	 20% 20%	 40% 40%

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Accidental Dental: $3,000 per accident (Network and Non-network combined)	Copayments/Coinsurance based on setting where covered services are received		40%
Behavioral Health Services[2]: **Mental Health and Substance Abuse** **(Network and Non-Network)**			
• Inpatient Facility Services	10%		40%
• Physician Home and Office Visits (PCP/SCP)	10%		40%
• Other Outpatient Services, Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional	10%		40%
Human Organ and Tissue Transplants[3]	No Cost Share	No Cost Share	40%
• Acquisition and transplant procedures, harvest and storage.			
Prescription Drugs National Rx Formulary **Network Tier structure equals 1/2/3** **(and 4, if applicable)**			
• **Network Retail Pharmacies:** (30-day supply) Includes diabetic test strip	$10/$35/$60/25% max $250		40% [5]
• **Home Delivery Service:** (90-day supply) Includes diabetic test strip	$20/$70/$125/25% max $250		Not covered
Member may be responsible for additional cost when not selecting the available generic drug. Medicare Rx - Wrap Specialty Medications are limited to 30 day supply regardless of whether they are retail or mail order.			

Notes:

- All medical and prescription drug deductibles, copayments and 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 Deductibles Tier 1 and Tier 2 commingle towards each other, meaning any amount applied to one network deductible will apply to the other as well (cross accumulate). After the Tier 1 deductible is satisfied, no additional deductible will be taken if services are only accessed on Tier 1. Network claims will continue to apply to the Tier 2 deductible until it is met for services accessed on both Tier 1 and Tier 2.
- Network and Non-network Deductibles, copayments, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- Out of Pocket (OOP) can only have one amount for Network benefits. All network covered services cost share for both Tier 1 and Tier 2 apply to the OOP.
- Dependent age: to end of the month which the child attains age 26
- Specialist copayment is applicable to all Specialists excluding General Physicians, Internist, Pediatricians, OB/GYNs and Geriatrics or any other Network Provider as allowed by the plan.

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- Emergency Room Services are subject to Tier 2 copayment, network services excluded from the copayment are subject to appropriate levels (T1/T2) Deductible and Coinsurance.
- Urgent Care network services copayment is subject to Tier 1 (T1) Deductible. T1 Coinsurance applies after copayment.
- No cost share (NCS) means no deductible/copayment/coinsurance up to the maximum allowable amount. 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.
- 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.
- Live Health Online (LHO) is covered at the Tier 1 PCP costshare.
- Certain diabetic and asthmatic supplies, except diabetic test strips, have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies.
- Benefit period = calendar year
- Mammograms (Diagnostic) are no copayment/coinsurance in Network office and outpatient facility settings.
- 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. Applies to all plans.
- Wigs limited to 1 per benefit period.

[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.
[5] 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.

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 benefit overview is for illustrative purposes and some content may be pending Ohio Department of Insurance approval.

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
Underwriting signature (if applicable)	Date

Language Access Services:

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Curious to know what all this says? We would be too. Here's the English version:
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(TTY/TDD: 711)

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Language Access Services: