Your summary of benefits

Anthem® BlueCross and BlueShield

Your Plan: Shawnee State University Anthem Blue Access Options PPO (3-Tier)with National Rx Formulary 1/2

Your Network: Blue Access OH I Effective Date 01/01/2019

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

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 Medical Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$500 person / $1,000 family	$1,500 person / $2,500 family	$2,000 person / $4,000 family
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.*	$3,500 person / $7,000 family	Combined with Tier 1	$6,000 person / $12,000 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	No charge	30%
Doctor Home and Office Services			
Primary Care Visit to treat an injury or illness *When Allergy injections are billed separately by network providers, the member is*	10%	20%	30%

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responsible for a $5 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.			
Specialist Care Visit *When Allergy injections are billed separately by network providers, the member is responsible for a $5 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	10%	20%	30%
Prenatal and Post-natal Care *In-Network preventive prenatal services are covered at 100%.*	10%	20%	30%
Other Practitioner Visits:			
Retail Health Clinic	10%	20%	30%
On-line Visit	10%	20%	30%
Manipulation Therapy *Coverage is limited to 30 visits per benefit period. Visit limits are combined both across outpatient and other professional visits. Limit is combined Preferred Network, In-Network and Non-Network.*	10%	20%	30%
Other Services in an Office:			
Allergy Testing	10%	20%	30%
Chemo/Radiation Therapy Performed by a Primary Care Physician	10%	20%	30%

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Chemo/Radiation Therapy Performed by a Specialist	10%	20%	30%
Dialysis/Hemodialysis	No charge	No charge	30%
Prescription Drugs *For the drugs itself dispensed in the office through infusion/injection.*	10%	20%	30%
Diagnostic Services			
Lab:			
Office	No charge	No charge	30%
Freestanding Lab/Reference Lab	No charge	No charge	30%
Outpatient Hospital	10%	20%	30%
X-Ray:			
Office	No charge	No charge	30%
Freestanding Radiology Center	No charge	No charge	30%
Outpatient Hospital	10%	20%	30%
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):			

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Office	10%	20%	30%
Freestanding Radiology Center	10%	20%	30%
Outpatient Hospital	10%	20%	30%
Emergency and Urgent Care			
Urgent Care (Office Setting) *Member cost share for Allergy injections billed separately is $5 copay. If billed with an Urgent Care Facility charge, it will be covered under the UC copayment, there is no additional cost to the member for the injection.*	10%	10%	30%
Urgent care(Facility Setting)			
Urgent Care: Facility fees	10%	10%	30%
Urgent Care: Doctor and other services	10%	10%	30%
Emergency Room Facility Services *Copay waived if admitted.*	$75	$75	$75
Emergency Room Doctor and Other Services	10%	10%	10%
Ambulance (Air, Ground, and Water) *Non-emergency non-network Ambulance Services are unlimited.*	10%	10%	10%

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Outpatient Mental/Behavioral Health and Substance Abuse			
Doctor Office Visit	10%	10%	30%
Facility visit:			
Facility Fees	10%	10%	30%
Doctor Services	10%	10%	30%
Outpatient Surgery			
Facility Fees:			
Hospital	10%	20%	30%
Freestanding Surgical Center	10%	20%	30%
Doctor and Other Services:			
Hospital	10%	20%	30%
Freestanding Surgical Center	10%	20%	30%

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Covered Medical Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)			
Facility fees (for example, room & board) *Coverage for Inpatient physical medicine and rehabilitation including day rehabilitation programs is limited to 60 days combined per benefit period. Limit is combined for Preferred, In-Network and Non-Network.*	10%	20%	30%
Human Organ and Tissue Transplants *Acquisition and transplant procedures, harvest and storage. Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.*	No charge	No charge	30%
Doctor and other services	10%	20%	30%
Recovery & Rehabilitation			
Home Health Care *Coverage is limited to 100 visits per benefit period. Limit is combined Preferred Network, In-Network and Non-Network.*	No charge	No charge	30%
Rehabilitation services (for example, physical/speech/occupational therapy):			
Office *Coverage for Occupational Therapy is limited to 30 visits per benefit period, Physical Therapy is limited to 30 visits per benefit period and Speech Therapy is limited to 30 visits per benefit period. Limit is combined for rehabilitative and habilitative services. Limit is combined Preferred Network, In-Network and*	10%	20%	30%

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Non-Network. Limit is combined across professional visits and outpatient facilities.			
Outpatient Hospital *Limit is combined for rehabilitative and habilitative services. Coverage for Occupational Therapy is limited to 30 visits per benefit period, Physical Therapy is limited to 30 visits per benefit period and Speech Therapy is limited to 30 visits per benefit period. Limit is combined Preferred Network, In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	10%	20%	30%
Cardiac rehabilitation Office *Coverage is unlimited visits per benefit period. Visit limits are combined both across outpatient and other professional visits. Limit is combined Preferred Network, In-Network and Non-Network.*	10%	20%	30%
Outpatient Hospital *Coverage is unlimited per benefit period. Limit is combined Preferred Network, In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits.*	10%	20%	30%
Pulmonary rehabilitation Office *Coverage is unlimited per benefit period. Visit limits are combined both across outpatient and other professional visits.*	10%	20%	30%
Outpatient Hospital *Coverage is unlimited per benefit period. Visit limits are combined both*	10%	20%	30%

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across outpatient and other professional visits.			
Skilled Nursing Care (in a facility) *Coverage is limited to 100 days per benefit period. Limit is combined Preferred Network, In-Network and Non-Network.*	10%	20%	30%
Hospice	No charge	No charge	No charge
Durable Medical Equipment	10%	20%	30%
Prosthetic Devices *Coverage is limited to 1 item per benefit period. Coverage for wigs needed after cancer treatment is limited to 1 item per benefit period. Limit is combined Preferred Network, In-Network, and Non-Network.*	10%	20%	30%

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Covered Prescription Drug Benefits	Cost if you use a Preferred Network Provider		Cost if you use a Non-Network Provider
Pharmacy Deductible	Not applicable		Not applicable
Pharmacy Out of Pocket	*Separate Rx Out of Pocket Single $4,150/ Family $8,800		*Separate Rx Out of Pocket Unlimited
Prescription Drug Coverage *National Rx Formulary* *This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.*			
Tier 1 - Typically Generic *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$10 copay per prescription, deductible does not apply (retail) and $20 copay per prescription, deductible does not apply (home delivery)		50% coinsurance (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$35 copay per prescription, deductible does not apply (retail) and $70 copay per prescription, deductible does not apply (home delivery)		50% coinsurance (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$60 copay per prescription, deductible does not apply (retail) and $120 copay per prescription, deductible does not apply (home delivery)		50% coinsurance (retail) and Not covered (home delivery)

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Covered Prescription Drug Benefits	Cost if you use a Preferred Network Provider		Cost if you use a Non-Network Provider
Tier 4 - Typically Specialty (brand and generic) *Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program). No coverage for non-formulary drugs.*	25% coinsurance up to $250 per prescription, deductible does not apply (retail and home delivery)		50% coinsurance (retail) and Not covered (home delivery)

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Notes:

- Dependent age: to end of the month in which the child attains age 26.
- No charge 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.
- Certain diabetic and asthmatic supplies are available at Network pharmacies, diabetic test strips paid same as any other drug.
- 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.
- Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.
- 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.
- 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).
- If office visit is a coinsurance, the coinsurance also applies to allergy injections.
- No Copayment or Coinsurance applies to certain diabetic and asthmatic supplies when you get them from an In-Network Pharmacy. These supplies are covered as Medical Supplies and Durable Medical Equipment if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance. Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.
- Benefit Year = Calendar Year
- 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.
- Network Deductibles Tier 1 and Tier 2 commingle towards each other.
- 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.
- All network covered services cost share for both Preferred and In-Network apply to the Network OOP.
- Urgent Care Facility Copay exclude certain diagnostic test such as MRAs, MRIs, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, Allergy Testing, and Pharmaceutical injection and drugs.

Your 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
Underwriting signature (if applicable)	Date

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If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (833) 639-1634

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(TTY/TDD: 711)

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Language Access Services:

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