

Your summary of benefits

Anthem® BlueCross and BlueShield

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

Your Network: Blue Access OH I Effective 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 <i>See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.</i>	\$3,000 Single / \$6,000 family	Combined with Tier 1	\$6,000 Single / \$12,000 Family
Out-of-Pocket Limit <i>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.</i>	\$6,000 Single / \$12,000 Family	Combined with Tier 1	\$12,700 person / \$25,400 family
Preventive care/screening/immunization <i>In-network preventive care is not subject to deductible, if your plan has a deductible.</i>	No charge	No charge	40%

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 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%

40%

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Specialist Care Visit <i>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.</i>	10%	20%	40%
Prenatal and Post-natal Care <i>In-Network preventive prenatal services are covered at 100%.</i>	10%	20%	40%
Other Practitioner Visits:			
Retail Health Clinic	10%	20%	40%
On-line Visit	10%	20%	40%
Manipulation Therapy <i>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.</i>	10%	20%	40%
Other Services in an Office:			
Allergy Testing	10%	20%	40%
Chemo/Radiation Therapy	10%	20%	40%
Dialysis/Hemodialysis	10%	20%	40%
Prescription Drugs <i>For the drugs itself dispensed in the office through infusion/injection.</i>	10%	20%	40%

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Diagnostic Services			
Lab:			
Office	10%	20%	40%
Freestanding Lab/Reference Lab	10%	20%	40%
Outpatient Hospital	10%	20%	40%
X-Ray:			
Office	10%	20%	40%
Freestanding Radiology Center	10%	20%	40%
Outpatient Hospital	10%	20%	40%
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):			
Office	10%	20%	40%
Freestanding Radiology Center	10%	20%	40%
Outpatient Hospital	10%	20%	40%

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Emergency and Urgent Care			
Urgent Care (Office Setting)	10%	10%	40%
Urgent care(Facility Setting)			
Urgent Care: Facility fees	10%	20%	40%
Urgent Care: Doctor and other services	10%	20%	40%
Emergency Room Facility Services	deductible then \$75	deductible then \$75	deductible then \$75
Emergency Room Doctor and Other Services	10%	10%	10%
Ambulance (Air, Ground, and Water) <i>Non-emergency non-network Ambulance Services are unlimited</i>	10%	10%	10%
Outpatient Mental/Behavioral Health and Substance Abuse			
Doctor Office Visit	10%	10%	40%
Facility visit:			
Facility Fees	10%	10%	40%
Doctor Services	10%	10%	40%

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Outpatient Surgery Facility Fees: Hospital Freestanding Surgical Center Doctor and Other Services: Hospital Freestanding Surgical Center	10% 10% 10% 10%	20% 20% 20% 20%	40% 40% 40% 40%
Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse) Facility fees (for example, room & board) <i>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.</i> Human Organ and Tissue Transplants <i>Acquisition and transplant procedures, harvest and storage. Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.</i> Doctor and other services	10% No charge 10%	20% No charge 20%	40% 40% 40%

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<p>Recovery & Rehabilitation</p> <p>Home Health Care <i>Coverage is limited to 100 visits per benefit period. Limit is combined Preferred Network, In-Network and Non-Network.</i></p>	10%	20%	40%
<p>Rehabilitation services (for example, physical/speech/occupational therapy):</p> <p>Office <i>Coverage for Occupational Therapy is limited to 20 visits per benefit period, Physical Therapy is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Limit is combined for rehabilitative and habilitative services. Limit is combined Preferred Network, In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.</i></p> <p>Outpatient Hospital <i>Limit is combined for rehabilitative and habilitative services. Coverage for Occupational Therapy is limited to 20 visits per benefit period, Physical Therapy is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Limit is combined Preferred Network, In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.</i></p>	10%	20%	40%
<p>Cardiac rehabilitation</p> <p>Office <i>Coverage is limited to 36 visits per benefit period. Visit limits are combined both across outpatient and other professional visits. Limit is combined Preferred Network, In-Network and Non-</i></p>	10%	20%	40%

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<p><i>Network.</i></p> <p>Outpatient Hospital <i>Coverage is limited to 36 visits per benefit period. Limit is combined Preferred Network, In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits.</i></p>	10%	20%	40%
<p>Pulmonary rehabilitation</p> <p>Office <i>Coverage is limited to 20 visits per benefit period. Visit limits are combined both across outpatient and other professional visits.</i></p> <p>Outpatient Hospital <i>Coverage is limited to 20 visits per benefit period. Visit limits are combined both across outpatient and other professional visits.</i></p>	10%	20%	40%
<p>Skilled Nursing Care (in a facility) <i>Coverage is limited to 100 days per benefit period. Limit is combined Preferred Network, In-Network and Non-Network.</i></p>	10%	20%	40%
<p>Hospice</p>	10%	10%	10%
<p>Durable Medical Equipment</p>	10%	20%	40%
<p>Prosthetic Devices <i>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.</i></p>	10%	20%	40%

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Provider		Cost if you use a Non-Network Provider
Pharmacy Deductible	Combined with In-Network medical deductible		Combined with medical deductible
Pharmacy Out of Pocket	Combined with In-Network medical out of pocket maximum		Combined with medical out of pocket maximum
Prescription Drug Coverage <i>National Rx Formulary</i> <i>This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.</i>			
Tier 1 - Typically Generic <i>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.</i>	\$10 copay per prescription, deductible does not apply (retail) and \$20 copay per prescription, deductible does not apply (home delivery)		40% (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand <i>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.</i>	\$35 copay per prescription deductible does not apply (retail) and \$70 copay per prescription, deductible does not apply (home delivery)		40% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand <i>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.</i>	\$60 copay per prescription deductible does not apply (retail) and \$120 copay per prescription, deductible does not apply (home delivery)		40% (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) <i>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.</i>	25% coinsurance up to \$250 per prescription, deductible does not apply (retail and home delivery)		40% (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 (HO'TT) Services).
- If office visit is a coinsurance, the coinsurance also applies to allergy injections.
Certain diabetic and asthmatic supplies are covered subject to applicable prescription drug copayments/coinsurance 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.
- 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.
- Benefit Period = Calendar Year

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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Questions: (833) 639-1634 or visit us at www.anthem.com

OH/LG/Anthem Blue Access Options PPO (3-Tier) HSAs 01-2019

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:

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

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

(TTY/TDD: 711)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (833) 639-1634.

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (833) 639-1634:

Chinese (中文): 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(833) 639-1634。

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French (Français): Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (833) 639-1634.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (833) 639-1634.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (833) 639-1634.

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Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(833) 639-1634로 문의하십시오.

Language Access Services:

Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'idiikidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj̄ bee nił hodoonih t'áadoo bą́ąh ilínígóó. Ata' halne'ígíí la' bich'į' hadeesdzih ninizingo koj̄' hodíílnih (833) 639-1634.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: (833) 639-1634.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (833) 639-1634 ਤੇ ਕਾਲ ਕਰੋ।

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (833) 639-1634.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (833) 639-1634.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (833) 639-1634.

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (833) 639-1634.

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