Your Summary of Benefits

Newark City Schools
Blue Access® (PPO)
Effective 07/01/2015

Covered Benefits	Network	Non-Network
Deductible (Single/Family)	$150/$300	$300/$600
Out-of-Pocket Limit (Single/Family)	$500/$1,000	$1,500/$3,000
Physician Home and Office Services (PCP/SCP) **Primary Care Physician (PCP)/** **Specialty Care Physician (SCP)** Including Office Surgeries and allergy serum:	$15/$15	20%
○ allergy injections (PCP and SCP)	$15	20%
○ allergy testing	10%	20%
○ MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds and pharmaceutical products	10%	20%
Preventive Care Services ○ Services included but not limited to: 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	20%
Emergency and Urgent Care		
Emergency Room Services ○ **facility/other covered services** (copayment waived if admitted)	10% (deductible does not apply)	10% (deductible does not apply)
Urgent Care Center Services	$25	20%
○ MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, Non-maternity related Ultrasounds and pharmaceutical products	10%	20%
○ Allergy injections	$15	20%
○ Allergy testing	10%	20%
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%
Blue 8.0		

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Inpatient Facility Services (Network/Non-Network combined) Unlimited days except for: • 90 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) • 180 days for skilled nursing facility	10%	20%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	10%	20%
Other Outpatient Services including but not limited to:		
• Non Surgical Outpatient Services for example: MRIs, C-Scans, Chemotherapy, Ultrasounds.	10%	20%
• Diagnostics Lab and X-Ray	No cost share	20%
• Home Care Services 180 visits (excludes IV Therapy) (Network/Non-Network combined)	10%	20%
• Durable Medical Equipment, Orthotics and Prosthetics	10%	20%
• Physical Medicine Therapy Day Rehabilitation programs	10%	20%
• Hospice Care	No cost share	No cost share
• Ambulance Services	10%	10%
Outpatient Therapy Services (Combined Network & Non-Network limits)		
• Physician Home and Office Visits (PCP/SCP)	$15/$15 (except manipulation)	20%
• Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: • Cardiac Rehabilitation 36 visits • Pulmonary Rehabilitation 20 visits • Physical Therapy: 20 visits • Occupational Therapy: 20 visits • Manipulation Therapy: 24 visits • Speech therapy: 50 visits	$15 (except manipulation) (Manipulation Therapy payable at 20%- deductible does not apply.)	20%
Accidental Dental:	Copayments/Coinsurance based on setting where covered services are received	20%
Behavioral Health: **Mental Illness and Substance Abuse**[2] • Inpatient Facility Services • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services. Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional	Benefits provided in accordance with Federal Mental Health Parity	20%
Human Organ and Tissue Transplants[3] • Acquisition and transplant procedures, harvest and storage.	No cost share	50%

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Prescription Drugs **Network Tier structure equals 1/2/3** **(and 4, if applicable)**		
○ **Retail Pharmacies:** (*30-day supply*) Includes diabetic test strip	$10/$20/$30	50%, min $30[5]
○ **Retail & Home Delivery Service:** (*90-day supply*) Includes diabetic test strip	$20/$40/$60	Not covered
Specialty medications are limited to a 30 day supply regardless of whether they are retail or home delivery. Specialty medications must be obtained via our Specialty Pharmacy network in order to receive network level benefits. Medicare Rx - Wrap		

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 covered medical services listed with a percentage (%) coinsurance, including 0%. However, the deductible does not apply to Emergency Room Services where a copayment & (%) coinsurance applies and may not apply to some Behavioral Health services where coinsurance applies
- Network and Non-network deductibles, 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
- 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.
- 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
- 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.
- Certain diabetic and asthmatic supplies have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies except diabetic test strips.
- **Benefit period = Plan 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.
- Vision limited services – additional vision services are covered when specifically coded as determination of refraction, routine ophthalmological examination including refraction for new and established patients, and a visual functional screening for visual acuity. No additional ophthalmological services are covered as part of the **medical** coverage.

[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

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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.

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