Your Summary of Benefits

Anthem BlueCross BlueShield

Blue Access® (PPO)
Effective 01/01/2017

Covered Benefits	Network	Non-Network
Deductible (Single/Family)	$300/$900	$700/$2,100
Out-of-Pocket Limit (Single/Family)	$2,000/$4,000	$3,500/$7,000
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 pharmaceutical products	$20/$30 $5 20% 20%	40% 40% 40% 40%
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	40%
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 pharmaceutical products • Allergy injections • Allergy testing	 $175 $50 20% $5 20%	 $175 40% 40% 40% 40%
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	20%	40%
Blue 8.6		

Your Summary of Benefits

Covered Benefits	Network	Non-Network
Inpatient Facility Services (Network/Non-Network combined) Unlimited days except for: • 100 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) • 100 days for skilled nursing facility	20%	40%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	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 60 visits (excludes IV Therapy) (Network/Non-Network combined) • Durable Medical Equipment, Orthotics and Prosthetics • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	20% No cost share 20%	40% No cost share 20%
Outpatient Therapy Services (Combined Network & Non-Network limits) • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: • Cardiac Rehabilitation 36 visits • Pulmonary Rehabilitation 20 visits • Physical Therapy: 30 visits • Occupational Therapy: 30 visits • Manipulation Therapy: 20 visits • Speech therapy: 20 visits	 $20[5] 20%	 40% 40%
Accidental Dental: Unlimited (Network and Non-network combined)	Copayments/Coinsurance based on setting where covered services are received	40%
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	 40%
Human Organ and Tissue Transplants[3] • Acquisition and transplant procedures, harvest and storage.	No cost share	50%

Your Summary of Benefits

Covered Benefits	Network	Non-Network
Prescription Drugs **Network Tier structure equals 1/2/3 (and 4, if applicable)**		
• **Network Retail Pharmacies:** (31- day supply) Includes diabetic test strip	$15/$30/$50/$100	$15/$30/$50/$100[4]
• **Home Delivery Service:** (90-day supply) Includes diabetic test strip	$37.50/$75/$125/$100 Mail required for certain medications after 3 refills at retail.	Not covered
Member may be responsible for additional cost when not selecting the available generic drug.		
Medicare Rx - Wrap		
Specialty Medications are limited up to a 31 day supply regardless of whether they are retail or mail service and must be obtained via our Specialty Pharmacy network in order to receive network level benefits.		

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 28;
- 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.
- Live Health Online (LHO) is covered at the 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
- 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.
- 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.

[4] Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.

[5] Non-Therapy services billed in conjunction with a therapy service (ex., evaluation and other related services) will pay based on place of service.

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 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