

# Your summary of benefits

Anthem® BlueCross and BlueShield

Greater Clark County Schools – Effective: 01/01/2020

Your Plan: Anthem Blue Access PPO HSAs

Your Network: Blue Access

*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 an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b> <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>	\$1,500 person / \$3,000 family	\$4,500 person / \$9,000 family
<b>Out-of-Pocket Limit</b> <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>	\$1,500 person / \$3,000 family	\$15,000 person / \$30,000 family
<b>Preventive care/screening/immunization</b> <i>In-network preventive care is not subject to deductible, if your plan has a deductible.</i>	No charge	30% coinsurance after deductible is met
<b>Doctor Home and Office Services</b>  <b>Primary Care Visit to treat an injury or illness</b>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Specialist Care Visit</b>	0% coinsurance after deductible is met	30% coinsurance after deductible is met



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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Prenatal and Post-natal Care</b> <i>In-Network preventive prenatal services are covered at 100%.</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Other Practitioner Visits:</b> Retail Health Clinic  On-line Visit <i>Includes Mental/Behavioral Health and Substance Abuse</i>  Manipulation Therapy <i>Coverage is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits.</i>	0% coinsurance after deductible is met  0% coinsurance after deductible is met  0% coinsurance after deductible is met	30% coinsurance after deductible is met  30% coinsurance after deductible is met  30% coinsurance after deductible is met
<b>Other Services in an Office:</b> Allergy Testing  Chemo/Radiation Therapy  Dialysis/Hemodialysis  Prescription Drugs <i>For the drugs itself dispensed in the office through infusion/injection.</i>	0% coinsurance after deductible is met  0% coinsurance after deductible is met  0% coinsurance after deductible is met  0% coinsurance after deductible is met	30% coinsurance after deductible is met  30% coinsurance after deductible is met  30% coinsurance after deductible is met  30% coinsurance after deductible is met



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<b>Diagnostic Services</b> <b>Lab:</b>  Office  Freestanding Lab/Reference Lab  Outpatient Hospital	 0% coinsurance after deductible is met  0% coinsurance after deductible is met  0% coinsurance after deductible is met	 30% coinsurance after deductible is met  30% coinsurance after deductible is met  30% coinsurance after deductible is met
<b>X-Ray:</b>  Office  Outpatient Hospital	 0% coinsurance after deductible is met  0% coinsurance after deductible is met	 30% coinsurance after deductible is met  30% coinsurance after deductible is met
<b>Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):</b>  Office  Freestanding Radiology Center  Outpatient Hospital	 0% coinsurance after deductible is met  0% coinsurance after deductible is met  0% coinsurance after deductible is met	 30% coinsurance after deductible is met  30% coinsurance after deductible is met  30% coinsurance after deductible is met





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<b>Emergency and Urgent Care</b> <b>Urgent Care (Office Setting)</b>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Urgent care(Facility Setting)</b> <b>Urgent Care: Facility fees</b>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Urgent Care: Doctor and other services</b>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Emergency Room Facility Services</b>	0% coinsurance after deductible is met	Covered as In-Network
<b>Emergency Room Doctor and Other Services</b>	0% coinsurance after deductible is met	Covered as In-Network
<b>Ambulance (Air, Ground, and Water)</b> <i>Non-emergency non-network Ambulance Services are limited to \$50,000 per occurrence.</i>	0% coinsurance after deductible is met	Covered as In-Network
<b>Outpatient Mental/Behavioral Health and Substance Abuse</b> <b>Doctor Office Visit</b>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Facility visit:</b> <b>Facility Fees</b>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Doctor Services</b>	0% coinsurance after deductible is met	30% coinsurance after deductible is met





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<b>Outpatient Surgery</b> <b>Facility Fees:</b> Hospital Freestanding Surgical Center  <b>Doctor and Other Services:</b> Hospital Freestanding Surgical Center	0% coinsurance after deductible is met 0% coinsurance after deductible is met  0% coinsurance after deductible is met 0% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met  30% coinsurance after deductible is met 30% coinsurance after deductible is met
<b>Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)</b> <b>Facility fees (for example, room &amp; board)</b> <i>Coverage for Skilled Nursing, Inpatient Physical Medicine and Rehabilitation including day rehabilitation is limited to 150 days combined per benefit period. Limit is combined In-Network and Non-Network.</i> <b>Human Organ and Tissue Transplants</b> <i>Acquisition and transplant procedures, collection and storage. Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.</i> <b>Doctor and other services</b>	0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met



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<b>Recovery &amp; Rehabilitation</b>  <b>Home Health Care</b> <i>Coverage is limited to 120 visits per benefit period. Limit is combined In-Network and Non-Network. Limits are combined for home health care and private duty nursing.</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Rehabilitation services (for example, physical/speech/occupational therapy):</b>  <b>Office</b> <i>Limit is combined for rehabilitative and habilitative services. Coverage for Occupational Therapy, Physical Therapy and Speech Therapy is unlimited per benefit period. Limit is combined for In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits.</i>  <b>Outpatient Hospital</b> <i>Limit is combined for rehabilitative and habilitative services. Coverage for Occupational Therapy, Physical Therapy and Speech Therapy is unlimited per benefit period. Limit is combined for In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits.</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Cardiac rehabilitation</b>  <b>Office</b> <i>Coverage is limited to 36 visits per benefit period. Limit is combined In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits.</i>  <b>Outpatient Hospital</b> <i>Coverage is limited to 36 visits per benefit period. Limit is combined In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits.</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Pulmonary rehabilitation</b>  <b>Office</b> <i>Coverage is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits.</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met



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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Outpatient Hospital</b> <i>Coverage is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits.</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Skilled Nursing Care (in a facility)</b> <i>Coverage for Skilled Nursing, Outpatient Rehabilitation and Inpatient Rehabilitation facility settings is limited to 150 days combined per benefit period. Limit is combined In-Network and Non-Network. Benefit includes coverage for Outpatient Rehabilitation program.</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Hospice</b>	0% coinsurance after deductible is met	Covered as In-Network
<b>Durable Medical Equipment</b>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Prosthetic Devices</b> <i>Coverage for scalp hair prosthetics and wigs after cancer treatment is limited to 1 item per benefit period. Limit is combined In-Network and Non-Network.</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met





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Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Pharmacy Deductible</b>	Combined with medical deductible	Combined with medical deductible
<b>Pharmacy Out of Pocket</b>	Combined with medical out of pocket maximum	Combined with medical out of pocket maximum
<b>Prescription Drug Coverage</b> <i>National Drug List</i> <i>This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.</i>		
<b>Tier 1 - Typically Generic</b> <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>	0% coinsurance after deductible is met (retail and home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)
<b>Tier 2 – Typically Preferred Brand</b> <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>	0% coinsurance after deductible is met (retail and home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)
<b>Tier 3 - Typically Non-Preferred Brand</b> <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>	0% coinsurance after deductible is met (retail and home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)
<b>Tier 4 - Typically Specialty (brand and generic)</b> <i>Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program).</i>	0% coinsurance after deductible is met (retail and home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)



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## Notes:

- The family deductible and out-of-pocket maximum are non-embedded meaning the cost shares of all family members apply to one shared family deductible and one shared family out-of-pocket maximum. The individual deductible and individual out-of-pocket maximum only apply to individuals enrolled under single coverage.
- 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 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.
- 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.
- 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.
- Benefits are limited to abortions due to an act of rape or incest, to avert death, or a substantial and irreversible impairment of a major bodily function.
- A Specialist copayment is applicable to care provided by Specialists, excluding General Physicians, Internist, Pediatricians and Geriatrics or other Network Provider as allowed by the plan.

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Greater Clark County Schools – BAHSA – Custom - National





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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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