Your Summary of Benefits

Gallipolis City Schools
Anthem Blue Access® PPO with Essential Rx Formulary
Effective 01/01/2019

Covered Benefits	Network	Non-Network
Deductible (Single/Family)	$3,000/$6,000	$5,000/$10,000
Out-of-Pocket Limit (Single/Family)	$5,000/$10,000	$10,000/$20,000
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	$30/$30 $5 20% 20%	50% 50% 50% 50%
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	50%
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	 $300 $30 20% $5 20%	 $300 50% 50% 50% 50%
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%	50%

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Inpatient Facility Services (Network/Non-Network combined) Unlimited days except for: • 60 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) • 90 days for skilled nursing facility	20%	50%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	20%	50%
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 • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	20% See note below for cost share details. 20% 20%	50% See note below for cost share details. 50% 20%
Outpatient Therapy Services (Combined Network & Non-Network limits) • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility Physical Medicine Therapy Limits, Outpatient Therapy (excludes Autism Spectrum Disorder)- (Network and Non-network combined): • Cardiac Rehabilitation 36 visits • Pulmonary Rehabilitation 20 visits • Physical Therapy: 20 visits • Occupational Therapy: 20 visits • Manipulation Therapy: 20 visits • Speech therapy: 20 visits Autism Spectrum Disorder Services Outpatient Therapy Limits under age 14 (Network and Non-network combined): • Occupational Therapy: 20 visits • Speech therapy: 20 visits • Clinical Therapeutic Intervention services: 20 hours weekly	 $30/$30 20%	 50% 50%
Accidental Dental: $3,000 per accident (Network and Non-network combined)	Copayments/Coinsurance based on setting where covered services are received	50%

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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	 20% $30 20%	 50% 50% 50%
Human Organ and Tissue Transplants[3] • Acquisition and transplant procedures, harvest and storage.	No cost share	50%
Prescription Drugs Essential Formulary** Network Tier structure equals 1/2/3 (and 4, if applicable) • Network Retail Pharmacies: (30-day supply) Includes diabetic test strip • Home Delivery Service: (90-day supply) Includes diabetic test strip Members have additional cost with retail supply greater than 30 days. Medicare Rx - Wrap Specialty Medications are limited up to a 30 day supply regardless of whether they are retail or mail service.	 $30/$50/$70 $75/$125/$175	 $30/$50/$70 Not covered

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.
- 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
- Diagnostic mammograms are not subject to Copayments / Coinsurance in Network office and outpatient facility settings. Routine mammograms are paid as Preventive Care services
- 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.

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- DME - 50% coinsurance for network/non-network Durable Medical Equipment and Medical Supplies. Excludes Prosthetics, Orthotics, Diabetic Supplies, Asthmatic Supplies, and Mastectomy Prostheses/etc. which will apply the plan's cost shares (common deductible/coinsurance).
- 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.

[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] If applicable, all prescription drug expenses except tier 1, (Network Retail/Home Delivery-service combined) apply to the per individual RX deductible. Once the RX deductible is met, the appropriate copayment applies.
[5] Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.
**The Rx option includes the Essential formulary which is a closed drug list with a focus on therapeutic efficacy and cost effectiveness.

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.

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

Language Access Services:

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 (855) 333-5735.

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(TTY/TDD: 711)

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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՝* (855) 333-5735

Chinese
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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 (855) 333-5735

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(Navajo) (Din4): D77 naaltsoos bik1'7g77 [ahgo b7na'7d7[kidgo n1 boh0n4edz3 d00 bee ah00t'i' t'11 ni nizaad k'ehj7 bee ni[hodoonih t'1adoo b33h 7l7n7g00. Ata' halne'7g77 [a' bich'8' hadeesdzih n7n7zingo koj8' hod77lnih (855) 333-5735.

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