Your Summary of Benefits

Anthem BlueCross BlueShield

Rolla #31 School District
Anthem Blue Access® PPO
Effective October 1, 2018

Base Plan

Covered Benefits	Network	Non-Network
Deductible (Single/Family)	$2,000/$6,000	$6,000/$18,000
Out-of-Pocket Limit (Single/Family)	$4,000/$8,000	$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/$50 $10 30% 30%	50% 50% 50% 50%
Preventive Care Services Services included but not limited to: • Routine medical exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations[1], Annual diabetic eye exam, Hearing screenings and Vision screenings which are limited to Screening tests (i.e. Snellen eye chart) and Ocular Photo screening • Immunizations through age 5	 No cost share No cost share	 50% No cost share
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	 30% 30% 30% $10 30%	 30% 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	30%	50%
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Inpatient Facility Services Unlimited days except for: • 60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) • 90 days Network/Non-Network combined for skilled nursing facility	30%	50%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	30%	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 100 visits (excludes IV Therapy) (Network/Non-Network combined) • Durable Medical Equipment • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	30% See note below for cost share details. 30% 30%	50% See note below for cost share details. 50% 20%
Outpatient Therapy Services (Combined Network & Non-Network limits apply) • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: • Physical/Manipulation therapy excluding Chiropractic Services: 20 visits • Occupational therapy: 20 visits • Chiropractic Services: 26 visits(Network only) • Speech therapy: Unlimited visits • Cardiac Rehabilitation: 36 visits • Pulmonary Rehabilitation: 20 visits	 $30/$50 30% See note below for cost share details	 50% 50% Not covered
Accidental Dental Services $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 Services[2]: Mental Health and Substance Abuse (Network and Non-Network) • Inpatient Facility Services • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services, Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional	 30% $30/$30 30%	 50%
Human Organ and Tissue Transplants[3] • Acquisition and transplant procedures, harvest and storage.	No Cost Share	50%
Prescription Drugs Anthem National Drug List Network Tier structure equals 1/2/3 (and 4, if applicable) • Network Retail Pharmacies: (30-day supply) Includes diabetic test strip • Anthem Rx Home Delivery Service: (90-day supply) Includes diabetic test strip Member may be responsible for additional cost when not selecting the available generic drug. Members have additional cost with retail supply greater than 30 days. Medicare Rx - Wrap Specialty Medications must be obtained via our Specialty Pharmacy network in order to receive network level benefits. Specialty medications are limited to 30 day supply regardless of whether they are retail or mail order.	 $15/$45/$75 $37.50/$135/$225/25% w $400 max	 50%[4] 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 and a percentage (%) 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 the end of the calendar year which the child attains age 26.
- When allergy injections are rendered with a Physicians Home and Office Visit, only the Office Visit cost share applies.
- Ambulance covered at the Network level. $50,000 Non-emergency Non-Network Limit applies.
- 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.
- Physical Therapy and Occupational Therapy will take the PCP cost share when performed in the Office visit setting.
- SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
- Specialist (SCP) copayment is applicable to all Specialists (excludes: General Physicians, Internists, Pediatricians, OB/Gyns, Geriatrics, Physical Therapy, Occupational Therapy or any other Network provider as allowed by the plan).
- 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.

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- Benefit period = calendar year
- Elective abortions are not covered.
- 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.
- Chiropractic services at 50% Network coinsurance up to the maximum allowable amount and the Deductible applies when Office Visit is Deductible and Coinsurance. Non-Network settings not covered.
- DME - 50% coinsurance for Network/Non-Network Durable Medical Equipment, Medical Supplies, Orthotics, Asthma Supplies, and Phenylketonuria (PKU). Excludes Prosthetics, Wigs, Diabetic 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 and 164 visits/lifetime

[1] These covered services for age 6 and above are not subject to the deductible/copayment if you have a flat dollar copayment and if rendered without an office visit
[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.
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[4] 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

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 Missouri 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

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

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