Your Anthem Benefits

Anthem

Pickerington Local Schools
Blue Access℠ (PPO)
Summary of Benefits, Effective 09/01/2017

Covered Benefits	Network	Non-Network
Deductible (Single/Family)	$500/$1,000	$1,000/$2,000
Out-of-Pocket Limit (Single/Family)	$1,500/$3,000	$3,000/$6,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/Specialty Care Physician (SCP) Including Office Surgeries and allergy serum:	$25/$35	30%
• allergy injections (PCP and SCP)	10%	30%
• allergy testing	10%	30%
• routine and non-routine mammograms (regardless of outpatient setting)	No copayment/coinsurance	30%
• diabetic education (regardless of outpatient setting)	No copayment/coinsurance	30%
• certain medical nutritional therapy (regardless of outpatient setting)	No copayment/coinsurance	30%
• MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies and non-maternity related Ultrasounds	10%	30%
Preventive Care Services Services include but are not limited to: Routine Exams, Pelvic Exams, Pap testing, PSA tests, Immunizations[1], Annual diabetic eye exam, Routine Vision and Hearing exams		
• Physician Home and Office Visits (PCP/SCP)	No copayment/coinsurance	30%
• Other Outpatient Services @ Hospital/Alternative Care Facility	No copayment/coinsurance	30%
Emergency and Urgent Care		
• Emergency Room Services @ Hospital (facility/other covered services) *(copayment waived if admitted)*	$150	$150
• Urgent Care Center Services	$35	$35
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%	30%
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) • 60 days Network/Non-Network combined for skilled nursing facility	10%	30%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	10%	30%
Other Outpatient Services *(including but not limited to):*		
• Non Surgical Outpatient Services for example: MRIs, C-Scans, Chemotherapy, Ultrasounds	10%	30%
• Home Care Services	10%	30%
• Durable Medical Equipment, Orthotics and Prosthetic Devices	10%	30%
• Physical Medicine Therapy Day Rehabilitation programs	10%	30%
• Hospice Care	10%	10%
• Ambulance Services	20%	20%

Covered Benefits	Network	Non-Network
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 therapy: 20 visits • Occupational therapy: 20 visits • Manipulation therapy: 16 visits • Speech therapy: 20 visits	 $25/$25 10%	 30% 30%
Behavioral Health Services • Inpatient Facility Services • Inpatient Professional Services • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services. Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional These benefits have been tested and are compliant with Federal Mental Health Parity legislation.	 10% 10% $25 10%	 30% 30% 30% 30%
Human Organ and Tissue Transplants[3] • Acquisition and transplant procedures, harvest and storage.	No copayment/coinsurance	50%
Prescription Drugs[4] Network Tier structure equals 1/2/3 (and 4, if applicable) • Network Retail Pharmacies: (30-day supply) Includes diabetic test strip • Anthem Rx Direct Mail Service: (90-day supply) Includes diabetic test strip Medicare Rx - Wrap	$100 Deductible (Network/Non-Network Combined) $15/$30/$45 $30/$60/$90	$100 Deductible (Network/Non-Network Combined) $15/$30/$45 Not covered

Notes:

- *All deductibles, copayments and coinsurance apply toward the out-of-pocket maximum including prescription drugs. (Excludes Non-network Human Organ and Tissue Transplant (HOTT) Services).*
- *Deductible(s) apply only to covered medical services listed with a percentage (%) coinsurance. However, the deductible does not apply to Emergency Room Services @ Hospital where a percentage (%) coinsurance applies to other covered services.*
- *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/GYN's and Geriatrics or any other Network Provider as allowed by the plan.*
- *Physicians Home and office visit copayment also applies if the office visit is billed with allergy injections.*
- *No copayment/coinsurance means no deductible/copayment/coinsurance up to the maximum allowable amount. 110% 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 = calendar year*

[1]These covered services 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 contact Our Mental Health Subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits for limitations. Behavioral Health Services (Mental Health and Substance Abuse) benefits provided in accordance with Federal Mental Health parity.
[3]Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.
[4] All prescription drug expenses except tier 1, (Network/Non-network, Retail/Mail-service combined) apply to the individual deductible. Once the deductible is met, the appropriate copayment applies. Also if applicable, the Prescription Drug out of pocket maximum applies to Network Retail and Mail-Service combined.
[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 avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.*

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.

Authorized group signature (if applicable)		Date
	Digitally signed by Timothy R. Jenkins DN: cn=Timothy R. Jenkins, o=Pickerington Local School District, ou=Pickerington Local School District, email=tjenkins@pickerington.k12.oh.us, c=US Date: 2017.05.16 09:03:19 -04'00'	May 16, 2017