Your Summary of Benefits

Anthem BlueCross BlueShield

Southern Local Schools
Blue Access® (PPO)
Effective 07/01/2017

Covered Benefits	Network	Non-Network
Deductible (Single/Family)	$250/$500	$500/$1,000
Out-of-Pocket Limit (Single/Family)	$2,250/$4,500	$4,500/$9,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/ Specialty Care Physician (SCP) Including Office Surgeries and allergy serum:	$10/$10	30%
○ allergy injections (PCP and SCP)	$5	30%
○ allergy testing	No cost share	30%
○ MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds and pharmaceutical products	No cost share	30%
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	30%
Emergency and Urgent Care **Emergency Room Services** ○ **facility/other covered services** (copayment waived if admitted)	$150	$150
Urgent Care Center Services	$50	30%
○ MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, Non-maternity related Ultrasounds and pharmaceutical products	No cost share	30%
○ Allergy injections	$5	30%
○ Allergy testing	No cost share	30%
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%

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Your Summary of Benefits

Covered Benefits	Network	Non-Network
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	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, and other diagnostic outpatient services. • Home Care Services 90 visits (excludes IV Therapy) (Network/Non-Network combined) • Durable Medical Equipment, Orthotics and Prosthetics • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	10% No cost share 10%	30% No cost share 10%
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 Unlimited • Pulmonary Rehabilitation Unlimited • Physical Therapy: 20 visits • Occupational Therapy: 20 visits • Manipulation Therapy: 12 visits • Speech therapy: 20 visits	 $10/$10 10%	 30% 30%
Accidental Dental: Unlimited (Network and Non-network combined)	Copayments/Coinsurance based on setting where covered services are received	30%
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	 30%
Human Organ and Tissue Transplants[3] • Acquisition and transplant procedures, harvest and storage.	10%	50%

Your Summary of Benefits

Covered Benefits	Network	Non-Network
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	$10/$25/$40	$30/$30/$30[5]
○ Home Delivery Service: (90-day supply) Includes diabetic test strip	$20/$40/$60	Not covered
Member may be responsible for additional cost when not selecting the available generic drug. Specialty Medications must be obtained via our Specialty Pharmacy network in order to receive network level benefits. Medicare Rx - Wrap	Prescription Drug out of pocket maximum network $4,350 single/$8,700 family	Prescription Drug out of pocket maximum non-network $8,700 single/$17,400 family
Specialty Medications are limited up to a 30 day supply regardless of whether they are retail or mail service.		

Notes:

- All medical deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services) Prescription Drug cost shares have a separate out of pocket.
- 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
- 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 62 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.

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) Christi D Hendrix	Date 5/15/2017
Underwriting signature (if applicable)	Date

Your Summary of Benefits

Anthem. BlueCross BlueShield

Southern Local Schools
Lumenos Health Savings Accounts Embedded
Effective 07/01/2017

Covered Benefits	Network	Non-Network
Deductible Embedded The single deductible applies to the Family deductible. Once the single deductible has been satisfied, benefits for that member are payable subject to coinsurance. Once the family deductible has been satisfied, benefits for the family are payable subject to coinsurance.	Single: $2,700 Family: $5,400	Single: $5,400 Family: $10,900
Out-of-Pocket Limit *	Single: $3,700 Family: $7,400	Single: $10,800 Family: $21,600
Physician Home and Office Services • Including Office Surgeries, allergy serum, allergy injections and allergy testing	0%	20%
Preventive Care Services Services include but are not limited to: Routine 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	20%
Emergency and Urgent Care • **Emergency Room Services @ Hospital (facility/other covered services)** (copayment waived if admitted) • **Urgent Care Center Services**	0% 0%	0% 20%
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	0%	20%
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) • 100 days for skilled nursing facility	0%	20%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	0%	20%

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Covered Benefits	Network	Non-Network
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	0% 0% 0%	20% 0% 0%
Accidental Dental Services- unlimited (Network and Non-network combined)	0%	20%
Outpatient Therapy Services (Combined Network & Non-Network limits apply) • Physician Home and Office Visits • Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: • Cardiac Rehabilitation unlimited • Pulmonary Rehabilitation – unlimited • Physical Therapy: 20 visits • Occupational Therapy: 20 visits • Manipulation Therapy: 12 visits • Speech therapy: 20 visits	 0% 0%	 20% 20%
Behavioral Health Services: **Mental Illness and Substance Abuse[1]** • Physician Home and Office Visits • Other Outpatient Services @ Hospital/Alternative Care Facility	Benefits provided in accordance with Federal Mental Health Parity	20%
Human Organ and Tissue Transplants • Acquisition and transplant procedures, harvest and storage.	0%	20%

Your Summary of Benefits

Covered Benefits	Network	Non-Network
Prescription Drugs		
○ **Network Retail Pharmacies:** (30-day supply) Includes diabetic test strip	$10/$25/$40/20%	50% min $40[2]
○ **Home Delivery Service:** (90-day supply) Includes diabetic test strip	$20/$40/$60/20%	Not covered
Specialty medications are limited up to a 30 day supply regardless of whether they are retail or mail service Member may be responsible for additional cost when not selecting the available generic drug		
Medicare Rx - Wrap		

Notes:

- All medical, deductibles and percentage (%) coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services)
- Deductible(s) apply to covered services listed with a percentage (%) coinsurance, including 0%.
- Deductible applies to all prescription drug expenses for Rx plans. Once the deductible is met the appropriate copayment/ coinsurance applies Copayments/coinsurance accumulate to the Medical OOP max. Once the Medical OOP max is met, no additional costshare applies.
- Network and Non-network Deductible, 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
- 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.
- No Cost Share (NCS): No deductible/copayment/coinsurance up to the maximum allowable amount.
- Live Health Online (LHO) is covered at the PCP costshare.
- Benefit period = calendar year
- 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
- Wigs limited to 1 per benefit period
- 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.

1 We encourage you to review the Schedule of Benefits for limitations.
2 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

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Authorized group signature (if applicable) Christi D Hendrix	Date 5/15/2017
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