

Your Summary of Benefits



**Southern Local Schools
Anthem Blue Access PPO for Health Savings Accounts Embedded
Effective 07/01/2018**

Covered Benefits	Network	Non-Network
Deductible 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 <ul style="list-style-type: none"> Including Office Surgeries, allergy serum, allergy injections and allergy testing 	0%	20%
Preventive Care Services <ul style="list-style-type: none"> 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	20%
Emergency and Urgent Care <ul style="list-style-type: none"> Emergency Room Services @ Hospital (facility/other covered services) (copayment waived if admitted) Urgent Care Center Services 	0%	0%
Inpatient and Outpatient Professional Services Include but are not limited to: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Surgery and administration of general anesthesia 	0%	20%

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Other Outpatient Services including but not limited to: <ul style="list-style-type: none"> 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%	20%
Accidental Dental Services Unlimited per accident (Network and Non-network combined)	0%	20%
Outpatient Therapy Services (Combined Network & Non-Network limits apply) <ul style="list-style-type: none"> Physician Home and Office Visits Other Outpatient Services @ Hospital/Alternative Care Facility Physical Medicine Therapy Limits, Outpatient Therapy (excludes Autism Spectrum Disorder)- (Network and Non-network combined): <ul style="list-style-type: none"> Cardiac Rehabilitation Unlimited Pulmonary Rehabilitation Unlimited Physical Therapy: 20 visits Occupational Therapy: 20 visits Manipulation Therapy: 12 visits Speech Therapy: 20 visits 	0%	20%
Behavioral Health Services: Mental Illness and Substance Abuse¹ <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Acquisition and transplant procedures, harvest and storage. 	0%	20%

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Prescription Drugs Anthem National Drug List <ul style="list-style-type: none"> ○ Network Retail Pharmacies: (30-day supply) Includes diabetic test strip ○ Home Delivery Service: (90-day supply) Includes diabetic test strip <p>Member may be responsible for additional cost when not selecting the available generic drug. Specialty medications are limited up to a 30 day supply regardless of whether they are retail or mail service Members have additional cost with retail supply greater than 30 days</p> <p>Medicare Rx - Wrap</p>	\$10/\$25/\$40/20% \$20/\$40/\$60/20%	50% min \$40 ² Not covered

Notes:

- All medical and drug cost shares, 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.
- Once the family deductible is satisfied by either one member or all members collectively, then the additional percentage coinsurance will be required before the family out-of-pocket is satisfied. Does not apply to embedded deductible plans.
- 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.
- Ambulance Non-network non-emergency use limited to \$50,000 per benefit period.
- 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. Applies to all plans.
- Wigs limited to 1 per benefit period

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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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) <i>Christi Hendrix</i>	Date <i>5/22/2018</i>
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.

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

(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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Language Access Services:

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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'1ladoo b33h 717n7g00. Ata' halne'7g77 [a' bich'8' hadeesdzih n7n7zingo koj8' hod77lnih (855) 333-5735.

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