

# Your Summary of Benefits



**Michigan City Area Schools - ESP  
Blue Access® (PPO) Option 3 with Rx Option E2  
Effective July 1, 2019**

Covered Benefits	Network	Non-Network
<b>Deductible (Single/Family)</b>	Single: \$500 Family: \$1,500	Single: \$1,000 Family: \$3,000
<b>Out-of-Pocket Limit (Single/Family)</b>	Single: \$2,500 Family: \$5,000	Single: \$5,000 Family: \$10,000
<b>Physician Home and Office Services (PCP/SCP)</b> Primary Care Physician (PCP)/ Specialty Care Physician (SCP) Including Office Surgeries and allergy serum: <ul style="list-style-type: none"> <li>allergy injections (PCP and SCP)</li> <li>allergy testing</li> <li>MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, and pharmaceutical products</li> </ul>	\$20/\$40  \$10 20% 20%	40%  40% 40% 40%
<b>Preventive Care Services</b> 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	40%
<b>Emergency and Urgent Care</b> <b>Emergency Room Services</b> <ul style="list-style-type: none"> <li>facility/other covered services (copayment waived if admitted)</li> </ul> <b>Urgent Care Center Services</b> <ul style="list-style-type: none"> <li>MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, and pharmaceutical products</li> <li>Allergy injections</li> <li>Allergy testing</li> </ul>	\$250/20%  \$75  \$10 20%	\$250/20%  40%  40% 40%
<b>Inpatient and Outpatient Professional Services</b> Include, but are not limited to: <ul style="list-style-type: none"> <li>Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams</li> </ul>	20%	40%
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Covered Benefits	Network	Non-Network
<b>Inpatient Facility Services</b> (Network/Non-Network combined) Unlimited days except for: <ul style="list-style-type: none"> <li>60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)</li> <li>90 days for skilled nursing facility</li> </ul>	20%	40%
<b>Outpatient Surgery Hospital/Alternative Care Facility</b> <ul style="list-style-type: none"> <li>Surgery and administration of general anesthesia</li> </ul>	20%	40%
<b>Other Outpatient Services</b> (including but not limited to): <ul style="list-style-type: none"> <li>Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services.</li> <li>Home Care Services (Network/Non-Network combined) 100 visits (excludes IV Therapy)</li> <li>Durable Medical Equipment, Orthotics and Prosthetics</li> <li>Physical Medicine Therapy Day Rehabilitation programs</li> <li>Hospice Care</li> <li>Ambulance Services</li> </ul>	20%	40%
<b>Outpatient Therapy Services</b> (Combined Network & Non-Network limits apply) <ul style="list-style-type: none"> <li>Physician Home and Office Visits (PCP/SCP)</li> <li>Other Outpatient Services @ Hospital/Alternative Care Facility</li> </ul> Limits apply to: <ul style="list-style-type: none"> <li>Physical therapy: 20 visits</li> <li>Occupational therapy: 20 visits</li> <li>Manipulation therapy: 12 visits</li> <li>Speech therapy: 20 visits</li> <li>Cardiac Rehabilitation: 36 visits</li> <li>Pulmonary Rehabilitation: 20 visits</li> </ul>	No cost share 20%	No cost share 20%
<b>Accidental Dental: \$3,000 per accident</b> (Network and Non-network combined)	Copayments/Coinsurance based on setting where covered services are received	40%
<b>Behavioral Health Services</b> <b>Mental Illness and Substance Abuse<sup>1</sup>:</b> <ul style="list-style-type: none"> <li>Inpatient Facility Services</li> <li>Physician Home and Office Visits (PCP/SCP)</li> <li>Other Outpatient Services, Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional</li> </ul>	Benefits provided in accordance with Federal Mental Health Parity	40%

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Covered Benefits	Network	Non-Network
<b>Human Organ and Tissue Transplants<sup>2</sup></b> <ul style="list-style-type: none"> <li>Acquisition and transplant procedures, harvest and storage</li> </ul>	No cost share	50%
<b>Prescription Drug Options: Essential Formulary*</b> <b>Network Tier structure equals 1/2/3</b> <b>(and 4/5, if applicable)</b> <ul style="list-style-type: none"> <li><b>Network Retail Pharmacies:</b> (30-day supply) Includes diabetic test strip</li> <li><b>Home Delivery Service:</b> (90-day supply) Includes diabetic test strip</li> </ul> <p>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.</p> <p><b>Medicare Rx - Wrap</b> 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.</p>	\$10/\$35/\$75/25% w/350 max  \$25/\$105/\$225/25% w/350max	50% <sup>3</sup>  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 coinsurance applies and may not apply to some Behavioral Health services where coinsurance applies.
- 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. If billed separately, Network Allergy injections are subject to the Allergy Injection \$10 copayment.
- Ambulance Non-network non-emergency use limited to \$50,000 per benefit period.
- NCS (No Cost Share) means no deductible/copayment/coinsurance up to the maximum allowable amount.
- 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
- Prosthetic limbs are unlimited and do not apply to the Plan Lifetime Maximum.
- 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 no deductible/coinsurance up to the maximum allowable amount.
- Private Duty Nursing – limited to 82 visits/Calendar Year and 164 visits/lifetime.
- Elective abortions not covered unless otherwise noted in your Certificate of Coverage.

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<sup>1</sup> We encourage you to review the Schedule of Benefits for limitations.

<sup>2</sup> Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.

<sup>3</sup> 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 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

# Your Summary of Benefits

## 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)**

**(Arabic)** (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (855) 333-5735

**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

**(中文):** 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (855) 333-5735

**(Farsi)** (فارسی): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (855) 333-5735 تماس بگیرید.

**French (Français):** Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (855) 333-5735.

**Haitian Creole (Kreyòl Ayisyen):** Si ou gen nennèt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (855) 333-5735.

**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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## **(Japanese) (日本語):**

この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(855) 333-5735 にお電話ください。

**Korean (한국어):** 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (855) 333-5735 로 문의하십시오.

**(Navajo) (Din4):** D77 naaltsoos bikl'7g77 [ahgo b7na'7d7[kidgo n1 boh0n4edz3 d00 bee ah00t'i' t'11 ni nizaad k'ehj7 bee ni[ hodoonih t'1adoo b33h 717n7g00. Ata' halne'7g77 [a' bich'8' hadeesdzh n7n7zingo koj8' hod771nih (855) 333-5735.

**Polish (polski):** W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (855) 333-5735.

**(Punjabi) (ਪੰਜਾਬੀ):** ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਇੱਕ ਦੁਬਾਰੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (855) 333-5735 ਤੇ ਕਾਲ ਕਰੋ।

**(Russian) (Русский):** если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (855) 333-5735.

**Spanish (Español):** Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (855) 333-5735.

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**Vietnamese (Tiếng Việt):** Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (855) 333-5735.

## **It's important we treat you fairly**

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help

(TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>