Your Summary of Benefits

Anthem

Educational Purchasing Council - Warren County ESC
Blue Access® (PPO)
Effective **January 1, 2019**

Please note: As we receive additional guidance and clarification from the U.S. Department of Health and Human Services, we may be required to make additional changes to your benefits.

Covered Benefits	Network	Non-Network
Deductible (Single/Family)	$100/$300	$200/$400
Out-of-Pocket Limit (Single/Family)	$1,000/$2,000	$2,000/$4,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/ Specialty Care Physician (SCP) Including Office Surgeries and allergy serum:	$20/$20	30%
• allergy injections (PCP and SCP)	$5	30%
• allergy testing	10%	30%
• routine and non-routine mammograms (regardless of outpatient setting)	No copayment/coinsurance	30%
• diabetic education (regardless of outpatient setting)	$20	30%
• certain medical nutritional therapy (regardless of outpatient setting)	$20	Not covered
• 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 screenings		
• 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	$100	$100
• facility/other covered services (copayment waived if admitted)		
Urgent Care Center Services	$50	$50
Inpatient and Outpatient Professional Services Include but are not limited to:	10%	30%
• Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams		
Blue 3.0		

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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) • 180 days for skilled nursing facility	10%	30%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	10%	30%
Other Outpatient Services (Combined Network & Non-Network limits) 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) • Durable Medical Equipment, Orthotics and Prosthetics • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	10% 10% No copayment/coinsurance	30% 10% No copayment/coinsurance
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: • Physical Therapy: 30 visits • Occupational Therapy: 30 visits • Manipulation Therapy: 12 visits • Speech therapy: 20 visits	 $20/$20 10%	 30% 30%
Behavioral Health: Mental Illness and Substance Abuse[2] • Inpatient Facility Services • Inpatient Professional Services • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services. Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional	 10% 10% $20/$20 10%	 30%
Human Organ and Tissue Transplants[3] • Acquisition and transplant procedures, harvest and storage.	No copayment/coinsurance	50%

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Prescription Drugs: Administered by CVS/Caremark	See Your Prescription Benefit Plan Summary	See Your Prescription Benefit Plan Summary
Lifetime Maximum	Unlimited	Unlimited

Notes:

- All medical deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Prescription Drug cost share options and 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 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/GYNs 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. 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.
- 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.

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.

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

Here's an overview of your CVS Caremark benefits.

Warren County ESC PPO - 01/01/2019

If you have any questions about your prescription plan or costs, call us at 1-888-202-1654. We can help any time after your plan starts. For TDD assistance, please call 1-800-863-5488.

	Short-Term Medicines CVS Caremark Retail Pharmacy Network (Up to a 30-day supply)	**Long-Term Medicines** CVS Caremark Mail Service Pharmacy (up to a 60-day supply) or CVS Pharmacy locations (up to a 90-day supply)
Generic Medicines Always ask your doctor if there's a generic option available. It could save you money.	**$10** for a generic medicine	**$10** for a generic medicine
Preferred Brand-Name Medicines If a generic is not available or appropriate, ask your doctor to prescribe from your plan's preferred drug list.	**$25** for a preferred brand-name medicine	**$25** for a preferred brand-name medicine
Non-Preferred Brand-Name Medicines Drugs that aren't on your plan's preferred list will cost more.	**$40** for a non-preferred brand-name medicine	**$40** for a non-preferred brand-name medicine
Refill Limit	**None**	**None**
Annual Deductible	**N/A**	
Maximum Out-of-Pocket	**$3,000 per individual / $6,000 per family**	
Out-of-Network Claims	Prescriptions filled at out-of-network pharmacies will be reimbursed at 50% of the cost of the claim.	
Prior Authorization	Certain medications may require prior authorization. Please contact Customer Care toll-free at 1-888-202-1654 or visit www.caremark.com for verification of prior authorization requirements.	
Specialty Medicines	Specialty medications are required to be filled through CVS Specialty Mail Order Pharmacy or at a retail CVS/pharmacy. Please contact Customer Care toll-free at 1-888-202-1654 for questions or to get started today.	

Please Note: When a generic is available, but the pharmacy dispenses the brand-name medication for any reason other than doctor or other prescriber indicates "dispense as written," you will pay the difference between the brand-name medication and the generic plus the brand copayment.

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Copayment, copay or coinsurance means the amount a plan member is required to pay for a prescription in accordance with a Plan which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.
Your feedback is important as it helps us improve our service. Please contact us with any questions or concerns at 1-888-202-1654.
Your privacy is important to us. Our employees are trained regarding the appropriate way to handle private health information.

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