

# Your Summary of Benefits



East Central College  
 Anthem Blue Access/Blue Access Choice and Blue Preferred Select PPO  
 Effective 1/1/2019

Covered Benefits	Network	Non-Network
<b>Deductible (Single/Family)</b>	\$2,500/\$5,000	\$5,000/\$10,000
<b>Out-of-Pocket Limit (Single/Family)</b>	\$5,000/\$10,000	\$10,000/\$20,000
<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, 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: <ul style="list-style-type: none"> <li>Routine medical exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations<sup>1</sup>, Annual diabetic eye exam, Hearing screenings and Vision screenings which are limited to Screening tests (i.e. Snellen eye chart) and Ocular Photo screening</li> <li>Immunizations through age 5</li> </ul>	No cost share   No cost share	40%   No cost share
<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, and pharmaceutical products</li> <li>Allergy injections</li> <li>Allergy testing</li> </ul>	\$200  \$50 20%  \$10 20%	\$200  40% 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%
Blue 11		

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<b>Behavioral Health Services<sup>2</sup>: Mental Health and Substance Abuse (Network and Non-Network)</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%
<b>Human Organ and Tissue Transplants<sup>3</sup></b> <ul style="list-style-type: none"> <li>Acquisition and transplant procedures, harvest and storage.</li> </ul>	No Cost Share	40%
Prescription Drugs <b>Essential Formulary**</b> <b>Network Tier structure equals 1/2/3 (and 4, 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>Anthem Rx 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.</p> <p>Members have additional cost with retail supply greater than 30 days.</p> <p>Medicare Rx - Wrap</p> <p><b>Specialty Medications</b> must be obtained via our Specialty Pharmacy network in order to receive network level benefits.</p> <p>Specialty medications are limited to 30 day supply regardless of whether they are retail or mail order.</p>	\$15/\$40/\$75  \$30/\$80/\$150	50% (min \$75) <sup>4</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 a percentage (%) 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.
- When allergy injections are rendered with a Physicians Home and Office Visit, only the Office Visit cost share applies.
- Ambulance covered at the Network level. \$50,000 Non-emergency Non-Network Limit applies.
- 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.
- Physical Therapy and Occupational Therapy will take the PCP cost share when performed in the Office visit setting.
- SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
- Specialist (SCP) copayment is applicable to all Specialists (excludes: General Physicians, Internists, Pediatricians, OB/Gyns, Geriatrics, Physical Therapy, Occupational Therapy or any other Network provider as allowed by the plan).
- 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.

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- Benefit period = calendar year
- Elective abortions are not covered.
- 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.
- Chiropractic services at 50% Network coinsurance up to the maximum allowable amount and the Deductible applies when Office Visit is Deductible and Coinsurance. Non-Network settings not covered.
- DME - 50% coinsurance for Network/Non-Network Durable Medical Equipment, Medical Supplies, Orthotics, Asthma Supplies, and Phenylketonuria (PKU). Excludes Prosthetics, Wigs, Diabetic Supplies and Mastectomy prostheses/etc. which will apply the plan's cost shares (common deductible/coinsurance).
- Private Duty Nursing – limited to 82 visits/Calendar Year and 164 visits/lifetime

<sup>1</sup> These covered services for age 6 and above are not subject to the deductible/copayment if you have a flat dollar copayment and if rendered without an office visit

<sup>2</sup> We encourage you to review the Schedule of Benefits for limitations.

<sup>3</sup> Kidney and cornea are treated the same as any other illness and subject to the medical benefits.

<sup>4</sup> If applicable, all prescription drug expenses except tier 1, (Network Retail/Mail-service combined) apply to the per individual RX deductible. Once the RX deductible is met, the appropriate copayment applies. Once the RX deductible is met, the appropriate copayment applies.

<sup>4</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 benefit overview is for illustrative purposes and some content may be pending Missouri 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)	Date
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)

**(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

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### 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

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**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 nenpòt 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

### (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。

## Language Access Services:

**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'ladoo b33h 717n7g00. Ata' halne'7g77 [a' bich'8' hadeesdzih n7n7zingo koj8' hod77lnih (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.

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**(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.

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