Your Summary of Benefits

East Central College
Anthem Blue Access/**Blue Access Choice/Blue Preferred Select** Health Savings Accounts
Effective **1/1/2019**

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: $5,000 Family: $10,000	Single: $5,000 Family: $10,000
Out-of-Pocket Limit	Single: $6,450 Family: $12,900	Single: $12,900 Family: $25,800
Physician Home and Office Services • Including Office Surgeries, allergy serum, allergy injections and allergy testing	0%	20%
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 • Immunizations through age 5	No cost share No cost share	20% No cost share
Emergency and Urgent Care • Emergency Room Services (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%
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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%

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Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	0%	20%
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% See note below for cost share details 0% 0%	20% See note below for cost share details 20% 0%
Accidental Dental Services $3,000 limit per accident (Network and Non-network combined)	Copayments/Coinsurance based on setting where covered services are received	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 36 visits • Pulmonary Rehabilitation 20 visits • Physical/Manipulation therapy excludes Chiropractic Services: : 20 visits • Occupational Therapy: 20 visits • Chiropractic Services: 26 visits (Network) • Speech therapy: Unlimited	 0% 0% See note below for cost share details	 20% 20% Not covered
Behavioral Health Services: Mental Illness and Substance Abuse[1] • Inpatient Facility Services • 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%

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Prescription Drugs Essential Formulary* Network Tier structure equals 1/2/3 (and 4, if applicable)		
• Network Retail Pharmacies: (30-day supply) Includes diabetic test strip	$15/$40/$75	50% (min $75)[2]
• Anthem Rx Home Delivery Service: (90-day supply) Includes diabetic test strip	$30/$80/$150	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.		
Members have additional cost with retail supply greater than 30 days.		
Medicare Rx - Wrap		

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 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 accumulates to the Medical OOP max. Once the Medical OOP max is met, no additional costshare applies.
- The family deductible must satisfied by either one family member's or all member's expenses collectively, then the percentage coinsurance applies until the family out of pocket limit is met. This does not apply to embedded plans.
- 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.
- Ambulance covered at the Network level. $50,000 Non-Emergency Non-network Limited applies.
- 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.
- No Cost Share (NCS): No deductible/copayment/coinsurance up to the maximum allowable amount
- Chiropractic services at 50% Network coinsurance up to the maximum allowable amount after the Deductible. Non-Network settings not covered.
- DME - 50% coinsurance for Network/Non-Network Durable Medical Equipment, Medical Supplies, Orthotics, Asthma Supplies, and Phenylketonuria (PKU) after the Deductible. 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.
- 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.
*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.

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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