Your Summary *of* Benefits

Anthem

MUSKEGO-NORWAY SCHOOL DISTRICT
Blue Priority® CalendarYear
Effective 09/01/2018

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.

Covered Benefits	Network	Non-Network
Deductible (Single/Family)	$500/$1,000	$1,000/$2,000
Out-of-Pocket Limit (Single/Family)	$2,000/$4,000	$4,000/$8,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician(PCP)/Specialty Care Physician (SCP) Including Office Surgeries and allergy serum: · Allergy injections (PCP and SCP) · Allergy testing · MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds and Pharmaceuticals	$30 / $50 10% 10% 10%	30% 30% 30% 30%
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. · Childhood Immunizations through age 18	No Cost Share	30%
Emergency and Urgent Care · **Emergency Room Services (facility/other covered services)** *(copayment waived if admitted)* · **Urgent Care Center Services** · MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, Non-Maternity related Ultrasounds and Pharmaceuticals · Allergy injections · Allergy testing	 $150/10% $50/10% 10% 10% 10%	 $150/10% 30% 30% 30% 30%
Inpatient and Outpatient Professional Services Include but are not limited to: · Medical Care visits, Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams	10%	30%
Inpatient Facility Services Unlimited days except for: ·Unlimited days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) · 100 days per admission Network/Non-Network combined for skilled nursing facility	10%	30%
Outpatient Surgery Hospital / Alternative Care Facility · Surgery and administration of general anesthesia	10%	30%
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 (Network/Non-network combined) Unlimited visits (excludes IV Therapy) · Durable Medical Equipment, Orthotics, and Prosthetics · Physical Medicine Therapy Day Rehabilitation programs · Ambulance Services	10% 10%	30% 10%

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Covered Benefits	Network	Non-Network
Outpatient Therapy Services		
(Combined Network & Non-Network limits apply)		
· Physician Home and Office Visits (PCP/SCP)	$30 / $50	30%
· Other Outpatient Services @ Hospital/Alternative Care Facility	10%	30%
Limits apply to:		
· Physical therapy: Unlimited visits		
· Occupational therapy: Unlimited visits		
· Speech therapy: Unlimited visits		
· Cardiac Rehabilitation: Unlimited visits		
· Pulmonary Rehabilitation: Unlimited visits		
· Accidental Dental Coverage		
Behavioral Health Services:		
Mental Health and Substance Abuse		
· Inpatient Facility Services	Benefits provided in accordance with	30%
· Physician Home and Office Visits	Federal Mental Health Parity	30%
· Other Outpatient Facility Services		30%
Human Organ and Tissue Transplants(1)	No Cost Share	30%
· Acquisition and transplant procedures, harvest and storage.		
Prescription Drugs:(2)		
Network Tier structure equals 1/2/3 (and 4 if applicable)		
· **Network Retail Pharmacies:**	$10 / $20 / $50 / $250	50% , min $25(3)
(30 day supply)		
Includes diabetic test strip		
· **Home Delivery**	$25 / $50 / $125 / $250	Not Covered
(90 day supply)		
Includes diabetic test strip		
4th Tier per script max- 30 day supply. Specialty medications are limited to a 30 day supply regardless of whether they are retail or home delivery.		
- Member may be responsible for additional cost when not selecting the available generic drug.		
- Specialty Medications must be obtained via our Specialty Pharmacy network in order to receive network level benefits.		

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 only to covered medical services listed with a percentage (%) coinsurance. 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. Network and non-network deductibles are combined.

· Dependent age: to the end of the month in which the child attains age 26.

· Specialist copayment is applicable to all Specialists excluding General Physicians, Internist, Pediatricians, OB/GYN's, Geriatrics and Chiropractors 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.

· No Cost Share 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.

· Chiropractor Services are subject to the PCP cost share.

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· Benefit period = Calendar Year
· Hospital stay for Maternity Coverage will not be limited to less than 48 hours for a vaginal delivery or 96 hours for a caesarean section
· Mammograms (diagnostic) have no copayment/coinsurance up to the maximum allowable amount in Network office and outpatient facility settings.
· Behavioral Health: 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 - Excluded
· Additional vision services covered as part of Preventive Services.
· Home Care Services (Network and Non-network combined) are unlimited visits.
· Hospice: coinsurance applies up to the maximum allowable amount .
(1)Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.
(2)All prescription drug expenses except tier 1, (Network/Non-Network, Retail/Home-delivery combined) apply to the per individual RX deductible. Once the RX deductible is met, the appropriate copayment/coinsurance applies. Also, the Prescription Drug out of pocket maximum applies to Network Retail and Home-delivery combined.
(3)Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.

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Exclusions

Your Plan does not provide coverage for the following: · Services that are not Medically Necessary. · Experimental/Investigative Services. · Complications directly related to a service or treatment that is a non Covered Service under this Certificate because it was determined by Us to be Experimental/ Investigative or non Medically Necessary. · Services received from a non-covered Provider. · For any condition arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. · Services provided by any governmental unit, unless otherwise required by law. · For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, whether declared or undeclared. · For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident. · For court ordered testing or care unless Medically Necessary. · For which you have no legal obligation to pay in the absence of this or like coverage. · For any Pre-Existing Condition for the time period specified in the Certificate. · Charges that are not documented in Provider records. · For mileage, lodging, and meals costs, and other Member travel related expenses, except as authorized by Us or specifically stated as a Covered Service. · For which benefits are payable under Medicare. · Charges in excess of Our Maximum Allowable Amounts. · Incurred prior to your Effective Date or after coverage ends. · For any procedures, services, Prescription Drugs, equipment, or supplies provided in connection with cosmetic services. This does not apply to services required as a result of an accident, to correct a birth defect, or as part of breast reconstruction following a mastectomy. Complications directly related to cosmetic services treatment or surgery are also not covered. · For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. · Custodial Care, convalescent care or rest cures. · Care provided or billed by residential treatment centers or facilities, unless those centers or facilities are required to be covered under state law. · For dental treatment, regardless of origin or cause, except as specified in the Certificate. · Weight loss programs except as specifically listed in the Certificate. · For bariatric surgery, regardless of the purpose it is proposed or performed for. Complications directly related to bariatric surgery are also not covered. · For marital counseling. · For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated in the Certificate. · For hearing aids or examinations for prescribing or fitting them. This exclusion does not apply to hearing aids or examinations required for children under age 18 who are receiving the benefits described in the "Covered Services" section. · For testing or treatment related to infertility. · For personal hygiene, environmental control, or convenience items including but not limited to air conditioners, physical fitness equipment, or charges from a health spa or similar facility. · For care received in an emergency room that is not Emergency Care, except as specified in the Certificate. · For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy. · For Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility. · Nutritional or dietary supplements. · For (services or supplies related to) alternative or complementary medicine, including but not limited to acupuncture, holistic medicine, hypnosis, massage therapy, and neurofeedback. · Treatment of varicose veins or spider veins. · Services for, and related to, many forms of immunotherapy including oral immunotherapy, low dose sublingual immunotherapy, and immunotherapy for food allergies. · Spinal decompression devices. This includes, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000. · Prescription Drugs dispensed by any Mail Service program other than Our Mail Service, unless prohibited by law. · Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original Prescription Order. · Drugs not approved by the FDA. · Drugs not requiring a Prescription by federal law (including Drugs requiring a Prescription by state law, but not by federal law), except for injectable insulin. · Drugs in quantities that exceed the limits established by the Plan, or which exceed any age limits established by Us. · Drugs to eliminate or reduce dependency on, or addiction to tobacco and tobacco products.

We conduct a variety of quality improvement programs to evaluate, monitor and improve our plans. The purpose of these programs is to measure member satisfaction and quality of care. Providers are also required to participate in a strict certification process. If you have questions or concerns about the programs, you may contact us at (800) 310-9975.

Precertification:

· Members are encouraged to always obtain prior approval when using Non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.

Pre-Existing Exclusion Period:*None.*

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.

Authorized group signature (if applicable)	Julie Kelley	*Date* 8-20-2018
Underwriting signature (if applicable)		*Date*