

Your Summary of Benefits



**ST. CHARLES SCHOOL DISTRICT
Blue Access and Blue Access Choice® PPO
Effective January 1, 2012**

Premium Plan

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)	\$0/\$0	\$300/\$600
Out-of-Pocket Limit (Single/Family)	None	\$3,000/\$6,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/ Specialty Care Physician (SCP) Including Office Surgeries and allergy serum: <ul style="list-style-type: none"> allergy injections (PCP and SCP) allergy testing MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, and pharmaceutical products 	\$20/\$30 \$5 No copayment/coinsurance No copayment/coinsurance	30% 30% 30% 30%
Preventive Care Services Services include but are not limited to: Routine Exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations ¹ , Annual diabetic eye exam, Routine Vision and Hearing screenings <ul style="list-style-type: none"> Physician Home and Office Visits (PCP/SCP) Other Outpatient Services @ Hospital/Alternative Care Facility Immunizations through age 5 	No copayment/coinsurance No copayment/coinsurance No copayment/coinsurance	30% 30% No copayment/coinsurance
Emergency and Urgent Care Emergency Room Services <ul style="list-style-type: none"> facility/other covered services (copayment waived if admitted) Urgent Care Center Services <ul style="list-style-type: none"> MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, and pharmaceutical products Allergy injections Allergy testing 	\$100 \$50 No copayment/coinsurance \$5 No copayment/coinsurance	\$100 30% 30% 30% 30%
Inpatient and Outpatient Professional Services Include but are not limited to: <ul style="list-style-type: none"> Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams 	No copayment/coinsurance	30%
Blue 5.0		

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Inpatient Facility Services Unlimited days except for: <ul style="list-style-type: none"> 60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) 90 days Network/Non-Network combined for skilled nursing facility 	No copayment/coinsurance	30%
Outpatient Surgery Hospital/Alternative Care Facility <ul style="list-style-type: none"> Surgery and administration of general anesthesia 	No copayment/coinsurance	30%
Other Outpatient Services (network & non network combined) (including but not limited to): <ul style="list-style-type: none"> 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 and Orthotics (excluding Prosthetic Devices, Limbs and Medical Supplies) Prosthetic Devices Prosthetic Limbs Physical Medicine Therapy Day Rehabilitation programs Hospice Care Ambulance Services 	No copayment/coinsurance No copayment/coinsurance No copayment/coinsurance	30% 30% No copayment/coinsurance
Outpatient Therapy Services (Combined Network & Non-Network limits apply) <ul style="list-style-type: none"> Physician Home and Office Visits (PCP/SCP) Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: <ul style="list-style-type: none"> Physical/Manipulation therapy excluding Chiropractic Services: 20 visits Occupational therapy: 20 visits Chiropractic Services: 26 visits(Network only) Speech therapy: Unlimited visits Cardiac Rehabilitation: 36 visits Pulmonary Rehabilitation: 20 visits 	\$20/\$30 No copayment/coinsurance	30% 30%
Accidental Dental Services \$3,000 limit (Network and Non-Network combined)	Copayments/Coinsurance based on setting where covered services are received	30%

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Behavioral Health Services²: Mental Health and Substance Abuse (Network and Non-Network) <ul style="list-style-type: none"> Inpatient Facility Services Inpatient Professional Services Physician Home and Office Visits (PCP/SCP) Other Outpatient Services, Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional 	No copayment/coinsurance No copayment/coinsurance \$20/\$30 No copayment/coinsurance	30%
Human Organ and Tissue Transplants³ <ul style="list-style-type: none"> Acquisition and transplant procedures, harvest and storage. 	No copayment/coinsurance	30%
Prescription Drugs⁴ Network Tier structure equals 1/2/3 <ul style="list-style-type: none"> Network Retail Pharmacies: (30-day supply) Includes diabetic test strip Anthem Rx Direct Mail Service: (90-day supply) Includes diabetic test strip <p>Member may be responsible for additional cost when not selecting the available generic drug.</p> <p>Medicare Rx - Wrap</p> <p>Specialty Medications must be obtained via our Specialty Pharmacy network in order to receive network level benefits.</p>	\$5/\$25/\$50* \$10/\$50/\$100* Out of Pocket Limit None	\$100 deductible 50% (min \$45) ⁵ Not covered
Lifetime Maximum	Unlimited	Unlimited

Notes:

- Flat dollar copayments and Non Network Human Organ and Tissue Transplants are excluded from the out-of-pocket limits. Also Prescription Drug deductibles/copayments/coinsurance are excluded from the out-of-pocket limits.
- 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.
- 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.
- 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.
- Certain diabetic and asthmatic supplies have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies, except diabetic test strips.
- Benefit period = calendar year

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- 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.
- Preventive Prescription Drugs that meet the requirements of federal and state law.
 1. 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
 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.
 3. Kidney and cornea are treated the same as any other illness and subject to the medical benefits.
 4. If applicable, all prescription drug expenses except tier 1, (Network/Non-network, Retail/Mail-service combined) apply to the per individual RX deductible. Once the RX deductible is met, the appropriate copayment applies. Also if applicable, the Prescription Drug out of pocket maximum applies to Network Retail and Mail-Service combined.
 5. Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.

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.

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.