Your Summary of Benefits

Anthem BlueCross BlueShield

Educational Purchasing Council - Xenia Community Schools
Lumenos Health Savings Account
Effective January 1, 2018

Covered Benefits	Network	Non-Network
Deductible Family coverage requires the family deductible to be met before coinsurance applies. The single deductible does not apply to family coverage.	Single: $2,000 Family: $4,000	Single: $2,000 Family: $4,000
Out-of-Pocket Limit	Single: $3,000 Family: $6,000	Single: $4,000 Family: $8,000
Physician Home and Office Services • Including Office Surgeries, allergy serum, allergy injections and allergy testing	0%	30%
Preventive Care Services Services include but are not limited to: Routine Exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Routine Vision and Hearing exams	No cost share	30%
Emergency and Urgent Care • **Emergency Room Services @ Hospital (facility/other covered services)** (copayment waived if admitted) • **Urgent Care Center Services**	0% 0%	0% 30%
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%	30%
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%	30%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	0%	30%
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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, Orthotics and Prosthetics • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	0% 0% 0%	30% 0% 0%
Accidental Dental Services $3,000 per accident (Network and Non-network combined)	0%	30%
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 Therapy: 30 visits • Occupational Therapy: 30 visits • Manipulation Therapy: 20 visits • Speech therapy: 20 visits	 0% 0%	 30% 30%
Behavioral Health Services: **Mental Illness and Substance Abuse[1]** • Physician Home and Office Visits • Other Outpatient Services @ Hospital/Alternative Care Facility	Benefits provided in accordance with Federal Mental Health Parity	30%
Human Organ and Tissue Transplants • Acquisition and transplant procedures, harvest and storage.	0%	30%
Prescription Drugs • **Network Retail Pharmacies:** (30-day supply) Includes diabetic test strips • **Home Delivery Service:** (90-day supply) Includes diabetic test strips	See your prescription drug summary	See your prescription drug summary

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Notes:

- All medical and drug cost shares, deductibles and percentage (%) 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 accumulate to the Medical OOP max. Once the Medical OOP max is met, no additional costshare applies.
- Network and Non-network **Deductible**, 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
- 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.
- 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.
- No Cost Share (NCS): No deductible/copayment/coinsurance up to the maximum allowable amount.
- 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. .

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 Ohio 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