Your Summary of Benefits

Anthem. BlueCross BlueShield

Westview School Corporation - Plan B
Blue Access® (PPO)
Effective January 1, 2019

Covered Benefits	Network	Non-Network
Deductible (Single/Family)	Single: $1,250 Family: $2,500	Single: $2,500 Family: $5,000
Out-of-Pocket Limit (Single/Family)	Single: $4,250 Family: $8,500	Single: $8,500 Family: $17,000
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 pharmaceutical products	$35/$35 $5 30% 30%	50% 50% 50% 50%
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	No cost share	50%
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 pharmaceutical products • Allergy injections • Allergy testing	 30% $60 30% $5 30%	 30% 30% 50% 50%
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	30%	50%
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Covered Benefits	Network	Non-Network
Inpatient Facility Services (Network/Non-Network combined) Unlimited days except for: • 60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) • 90 days for skilled nursing facility	30%	50%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	30%	50%
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) 100 visits (excludes IV Therapy) • Durable Medical Equipment, Orthotics and Prosthetics • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	30% No cost share 30%	50% No cost share 30%
Outpatient Therapy Services (Combined Network & Non-Network limits apply) • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: • Physical therapy: 45 Visits • Occupational therapy: 45 visits • Manipulation therapy: 24 visits • Speech therapy: 40 visits • Cardiac Rehabilitation: 36 visits • Pulmonary Rehabilitation: 20 visits	 $35/$35 30%	 50% 50%
Accidental Dental: $3,000 per accident (Network and Non-network combined)	Copayments/Coinsurance based on setting where covered services are received	50%
Behavioral Health Services **Mental Illness and Substance Abuse[1]:** • Inpatient Facility Services • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services, Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional	 30% $35/$35 30%	 50%

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Covered Benefits	Network	Non-Network
Human Organ and Tissue Transplants[2] • Acquisition and transplant procedures, harvest and storage	No cost share	50%
Prescription Drug Options: Anthem Essential Drug List **Network Tier structure equals 1/2/3** (and 4/5, if applicable)		
• **Network Retail Pharmacies:** (30-day supply) Includes diabetic test strip	$15/$50/$75	50%, min $40[3]
• **Home Delivery Service:** (90-day supply) Includes diabetic test strip	$30/$100/$150	Not covered
• **Preferred Specialty/Non-Preferred Specialty**		
Member may be responsible for additional cost when not selecting the available generic drug.	N/A	
Members have additional cost with retail supply greater than 30 days.	RX OOP $3,350/$6,700	
Medicare Rx - Wrap		
Specialty Medications must be obtained via our Specialty Pharmacy network in order to receive network level benefits Specialty medications are limited to 30 day supply regardless of whether they are retail or mail order.		

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 coinsurance applies and may not apply to some Behavioral Health services where coinsurance applies.
- 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. When the Office Visit cost share is a % coinsurance, deductible and coinsurance apply to allergy injections. If billed separately, Network Allergy injections are subject to the Allergy Injection $5 copayment.
- NCS (No Cost Share) means no deductible/copayment/coinsurance up to the maximum allowable amount.
- 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.
- 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.
- Benefit period = calendar year
- 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 no deductible/coinsurance up to the maximum allowable amount.
- Private Duty Nursing – limited to 82 visits/Calendar Year and 164 visits/lifetime.
- Elective abortions not covered unless otherwise noted in your Certificate of Coverage.

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[1]We encourage you to review the Schedule of Benefits for limitations.
[2] Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.
[3]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 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 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.

Your Anthem Benefits

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Westview School Corporation
Anthem Dental Traditional (group size 51+)
Summary of Benefits, Effective January 1, 2019

This is not a contract; it is a partial listing of benefits and services. All covered services are subject to the conditions, exclusions, qualifications, limitations, terms and provisions of the Dental Certificate.

BENEFITS	MEMBER'S RESPONSIBILITY
Annual Deductible (Single/Family)	$25/$75
Annual Maximum	$1,000
Class I PREVENTIVE Services Include exams, oral evaluations, x-rays (bitewing and complete series), cleaning and scaling, space maintainers and other selected diagnostic and preventive services *(Limits may apply) Please refer to your certificate for additional information.*	Covered in Full
Class II BASIC SERVICES	
Class II A General Services Include palliative (emergency) treatment, consultations, general anesthesia, intravenous sedation, office visits for observation, amalgam and composite restorations and pin retention procedures	20%
Class II B Specialty Services Include root canal therapy, apexification/recalcification, therapeutic pulpotomy, oral surgery, simple and surgical tooth extractions, periodontic services, gingivectomy, osseous surgery and other selected endodontic, oral surgery and periodontal services. *(Limits may apply) Please refer to your certificate for additional information.*	20%
Class III MAJOR SERVICES	
Prosthodontic Services Include onlays, crowns, dentures, bridges and repair of dentures and bridgework, implants and other selected prosthodontic services	50%
Missing Tooth Benefit Services for the replacement of teeth (tooth) lost prior to the member's effective date of coverage under this plan. • Removable prosthodontics (partials or dentures) • Fixed prosthodontics (bridges) for the replacement of teeth (or tooth) *A waiting period and/or limits may apply. Please refer to your certificate for additional information.*	Covered
Class IV ORTHODONTIC *(no deductible)*	50% Child only to end of calendar year age 23
Orthodontic Services Include examination, records, minor treatment of tooth guidance, repositioning (straightening) of the teeth, interceptive or comprehensive orthodontic treatment, post-treatment stabilization. *A waiting period and/or limits may apply. Please refer to your certificate for additional information*	
Separate Orthodontic Lifetime Maximum	$1,000