Your Summary *of* Benefits

Anthem

Missouri Valley Conference
Blue Access® Choice Option 2 with Rx Option N
Effective 01/01/2020

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/$1,500	$1,000/$3,000
Out-of-Pocket Limit (Single/Family)	$500/$1,500	$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:	$20 / $40	30%
· Allergy injections (PCP and SCP)	$5	30%
· Allergy testing	0%	30%
· MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds and Pharmaceuticals	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 screenings	No Copayment/Coinsurance	30%
· Immunizations through age 5		No Copayment/Coinsurance
Emergency and Urgent Care		
· **Emergency Room Services (facility/other covered services)** *(copayment waived if admitted)*	$200	$200
· **Urgent Care Center Services**	$75	30%
· MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, Non-Maternity related Ultrasounds and Pharmaceuticals	0%	30%
· Allergy injections	$5	30%
· Allergy testing	0%	30%
Inpatient and Outpatient Professional Services Include but are not limited to:	0%	30%
· Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams		
Inpatient Facility Services Unlimited days except for:	0%	30%
· 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		
Outpatient Surgery Hospital / Alternative Care Facility	0%	30%
· Surgery and administration of general anesthesia		
Other Outpatient Services (including but not limited to):	0%	30%
· Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services.		
· Home Care Services (Network/Non-network combined) 90 visits (excludes IV Therapy)		
· Durable Medical Equipment, Orthotics, and Prosthetics		
· Physical Medicine Therapy Day Rehabilitation programs		
· Hospice Care	0%	30%
· Ambulance Services	0%	0%

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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) · Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: · Physical / Manipulation therapy excludes Chiropractic Services: 20 visits · Occupational therapy: 20 visits · Chiropractic Services: 26 visits (Network) Non-Network Not Covered · Speech therapy: Unlimited visits · Cardiac Rehabilitation: 36 visits · Pulmonary Rehabilitation: 20 visits · Accidental Dental: $3,000 Limit	 $20 / $40 0%	 30% 30%
Behavioral Health Services: (Network and Non-Network) **Mental Health and Substance Abuse** · Inpatient Facility Services · Physician Home and Office Visits · Other Outpatient Services @ Hospital/Alternative Care Facility **Substance Abuse Limits** **· Inpatient: 21 days, 6 separate days for detox** **· Outpatient Facility: 30 visits** **· Outpatient Office Visits: 30 visits** *(Substance abuse rehabilitation programs are limited to 10 episodes per lifetime Network and Non-Network combined.)*	 0% $40 0%	 30% 30% 30%
Human Organ and Tissue Transplants (1) · Acquisition and transplant procedures, harvest and storage.	No Copayment/Coinsurance	30%
Prescription Drugs (National):(2) **Network Tier structure equals 1/2/3 (and 4 and 5 if applicable)** **· Network Retail Pharmacies:** (30 day supply) Includes diabetic test strip **· Anthem Mail Service:** (90 day supply) Includes diabetic test strip 4th Tier per script max-$150 30 day supply. Specialty medications are limited 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. - Specialty Medications must be obtained via our Specialty Pharmacy network in order to receive network level benefits.	 $10 / $35 / $60 / 25% $150 max up to $2,500 $10 / $90 / $180 / 25% $150 max up to $2,500	 50% , min $60(3) Not Covered

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 @ Hospital where a copayment and 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 for 500 series plans.
· Physical Therapy and Occupational Therapy will take the PCP cost share when performed in the office visit setting.
· Dependent age: to the end of the month in which the child attains age 26.

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· Specialist (SCP) copayment is applicable to all Specialists (excludes: General Physicians, Internists, Pediatricians, OB/Gyns, Geriatrics, Physical Therapy, Occupational Therapy 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
· Mammograms (diagnostic) have no copayment/coinsurance up to the maximum allowable amount in Network office and outpatient facility settings.
· Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are covered.
(1) Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.
(2) 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/coinsurance applies. Also, if applicable, the Prescription Drug out of pocket maximum applies to Network Retail and Mail-service combined.
(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 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)	*Date*
Underwriting signature (if applicable)	*Date*