

Your Summary of Benefits



Centre College
Blue Access® (PPO)
Effective 12/01/2011

Covered Benefits	Network	Non-network
Deductible (Single/Family)	\$200/\$400	\$200/\$400
Out-of-Pocket Maximum (Single/Family)	\$1,200/\$2,400	\$1,200/\$2,400
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 	20%/20%	40%
Preventive Care Services Services include but are not limited to: Routine Exams, Pelvic Exams, Pap testing, PSA tests, Immunizations ¹ , Annual diabetic eye exam, Vision and Hearing screenings <ul style="list-style-type: none"> Physician Home and Office Visits (PCP/SCP) Other Outpatient Services @ Hospital/Alternative Care Facility 	No copayment/coinsurance Per Plan document.(2) Other preventive services are subject to deductible and 20%	40% 40%
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	20%	20%
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 	20%	40%
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 	20%	40%
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Outpatient Surgery Hospital/Alternative Care Facility <ul style="list-style-type: none"> Surgery and administration of general anesthesia 	20%	40%
Other Outpatient Services (Combined Network & Non-Network limits) 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 Prosthetic Devices Prosthetic Limbs Physical Medicine Therapy Day Rehabilitation programs Hospice Care Ambulance Services 	20%	40%
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 Therapy: 30 visits Occupational Therapy: 30 visits Manipulation Therapy: 30 visits Speech therapy: 30 visits 	No copayment/coinsurance 20%	No copayment/coinsurance 20%
Accidental Dental:	Copayments/Coinsurance based on setting where covered services are received	40%
Behavioral Health: Mental Illness and Substance Abuse² <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 	20%	40%
Human Organ and Tissue Transplants³ <ul style="list-style-type: none"> Acquisition and transplant procedures, harvest and storage 	No copayment/coinsurance	50%

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Prescription Drug Options: 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 Medicare RX - Wrap Specialty Medications must be obtained via our Specialty Pharmacy network in order to receive network level benefits.	\$\$10/\$25/\$40/20% \$20/\$50/\$80/20% Out of Pocket Limit \$1,200-4th tier	50%, min \$40 ⁵ Not covered
Lifetime Maximum	Unlimited	Unlimited

Notes:

- Flat dollar copayments are excluded from the out-of-pocket limits. Also Prescription Drug deductibles/copayments/coinsurance and Non-network Human Organ and Tissue Transplants 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 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.
- Autism Spectrum Disorder is covered based on state law for members age 1 through 21.
- Benefit period = calendar year
- Mammograms (Routine and diagnostic), Diabetic Education and Medical Nutritional Therapy are subject to the PCP/OV cost share 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 covered.

¹ These covered services 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 refer to the Schedule of Benefits for limitations.

³ Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.

⁴ Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.

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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.

Grandfathered Health Plan

Anthem Blue Cross and Blue Shield believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections of the Affordable Care Act apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Anthem Blue Cross and Blue Shield at the telephone number printed on the back of your member identification card, or contact your group benefits administrator if you do not have an identification card. For ERISA plans, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. *This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For nonfederal governmental plans, you may also contact the U.S. Department of Health and Human Services at www.healthcare.gov.*

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.