Ashtabula County Schools Council of Governments: Ashtabula County ESC, PPO

Coverage Period: 10/01/2016 - 09/30/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual/Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document for medical at www.anthem.com or by calling 1-800-418-1112 and for prescription drug at www.caremark.com or 1- 800-776-1355.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$100** Individual/**$200** Family for In-Network Providers. **$200** Individual/ **$400** Family for Out- of-Network Providers. Doesn't apply to In-Network Preventive care. In-Network and Out-of-Network Provider deductibles are separate and do not count towards each other.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$300** Individual/**$600** Family for In-Network Providers. **$2,000** Individual/**$4,000** Family for Out-of-Network Providers. In-Network and Out-of-Network Provider out-of-pocket are separate and do not count towards each other. This plan has a separate Network Medical Copayment Out-of-Pocket Maximum of **$3,550** Individual/**$7,100** Family and Network Prescription Drug Copayment Out-of-Pocket Maximum of **$3,000** individual and **$6,000** Family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Prescription Drug, Premiums, Balance-billed charges and Health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.

Questions: For medical call 1-800-418-1112 or visit us at www.anthem.com
and for prescription drug at 1- 800-776-1355 or www.caremark.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.cciio.cms.gov** or call 1-800-418-1112 to request a copy.

Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For medical visit www.anthem.com or call 1-800-418-1112 for a list of Network Providers. For prescription drug visit www.caremark.com or call 1-800-776-1355.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers.**
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**$15** Copay/Visit	**30%** Coinsurance	--------none--------
	Specialist visit	**$15** Copay/Visit	**30%** Coinsurance	--------none--------
	Other practitioner office visit	Manipulative Therapy **$15** Copay/Visit Acupuncturist Not Covered	Manipulative Therapy **30%** Coinsurance Acupuncturist Not Covered	Manipulative Therapy Coverage is limited to 12 visits per Benefit Period for Spinal Manipulations combined In-Network and Out-of-Network Providers. Costs may vary by site of service. You should refer to your formal contract of coverage for details.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Preventive care/screening/immunization	**No Cost Share**	**30%** Coinsurance	--------none--------
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office No Cost Share X-Ray – Office No Cost Share	Lab – Office No Cost Share X-Ray – Office No Cost Share	Lab – Office Failure to obtain pre-certification may result in non-coverage or reduced benefits for the below services: Diagnosis of Sleep Disorders, Gene Expression Profiling for Managing Breast Cancer Treatment and Genetic Testing for Cancer Susceptibility. Costs may vary by site of service. You should refer to your formal contract of coverage for details. X-Ray – Office Failure to obtain pre-certification may result in non-coverage or reduced benefits for the below services: Diagnosis of Sleep Disorders, Gene Expression Profiling for Managing Breast Cancer Treatment and Genetic Testing for Cancer Susceptibility. Costs may vary by site of service. You should refer to your formal contract of coverage for details.
	Imaging (CT/PET scans, MRIs)	No Cost Share	No Cost Share	Failure to obtain pre-certification may result in non-coverage or reduced benefits for the below service: MRI Guided High Intensity Focused Ultrasound Ablation of Uterine Fibroids.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com.	Generic	$5 retail/$10 mail	Not Covered	Prescription Drug coverage is administered by CVS Caremark. Covers up to a 34-day supply (retail prescription); 35-90 day supply available through mail order.
	Preferred/Formulary Brand	$15 retail/$30 mail	Not Covered	
	Non- preferred/Non-formulary Drugs	$20 retail/$40 mail	Not Covered	
	Specialty Drugs	$20 retail/$40 mail	Not Covered	Specialty drugs must be obtained through Caremark; Up to a 30 day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**10%** Coinsurance	**30%** Coinsurance	--------none--------
	Physician/surgeon fees	**10%** Coinsurance	**30%** Coinsurance	--------none--------
If you need immediate medical attention	Emergency room services	**$75** Copay/Visit	**$75** Copay/Visit	If admitted, ER Copay is waived. Failure to obtain pre-certification for Emergency Admissions (Requires Plan notification no later than 2 business days after admission) may result in non-coverage
	Emergency medical	No Cost Share	No Cost Share	--------none--------
	Urgent care	**$15** Copay/Visit	**30%** Coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	**10%** Coinsurance	**30%** Coinsurance	--------none--------
	Physician/surgeon fee	**10%** Coinsurance	**30%** Coinsurance	--------none--------

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit **$15** Copay/Visit Mental/Behavioral Health Facility Visit – Facility Charges **10%** Coinsurance	Mental/Behavioral Health Office Visit **30%** Coinsurance Mental/Behavioral Health Facility Visit – Facility Charges **30%** Coinsurance	Mental/Behavioral Health Office Visit --------none-------- Mental/Behavioral Health Facility Visit – Facility Charges Pre-certification may be required after the initial twelve (12) visits. Please call the plan for account-specific details.
	Mental/Behavioral health inpatient services	**10%** Coinsurance	**30%** Coinsurance	--------none--------
	Substance use disorder outpatient services	Substance abuse Office Visit **$15** Copay/Visit Substance abuse Facility Visit – Facility Charges **10%** Coinsurance	Substance abuse Office Visit **30%** Coinsurance Substance abuse Facility Visit – Facility Charges **30%** Coinsurance	Substance abuse Office Visit --------none-------- Substance abuse Facility Visit – Facility Charges Pre-certification may be required after the initial twelve (12) visits. Please call the plan for account-specific details.
	Substance use disorder inpatient services	**10%** Coinsurance	**30%** Coinsurance	--------none--------
If you are pregnant	Prenatal and postnatal care	**$15** Copay/Visit	**30%** Coinsurance	Copay applies for 1st Prenatal Visit. There may be other levels of cost share that are contingent on how services are provided, please see your formal contract of coverage for a complete explanation.
	Delivery and all inpatient services	**10% Coinsurance**	**30%** Coinsurance	Failure to obtain pre-certification may result in non-coverage or reduced benefits for OB delivery stays beyond the Federal Mandate minimum LOS (including newborn stays beyond the mother's stay). Applies to inpatient facility. Other cost shares may apply depending on the services provided.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	**10%** Coinsurance	**30%** Coinsurance	Coverage is limited to 180 days per Benefit Period combined In-Network and Out-of-Network Providers.
	Rehabilitation services	**$15** Copay/Visit	**30%** Coinsurance	Coverage is limited to 30 visits per Benefit Period for each Physical Therapy and Occupational Therapy.
	Habilitation services	**$15** Copay/Visit	**30%** Coinsurance	Habilitation visits count towards your Rehabilitation limit.
	Skilled nursing care	**10%** Coinsurance	**30%** Coinsurance	Coverage is limited to 120 days maximum per Benefit Period.
	Durable medical equipment	**10%** Coinsurance	**30%** Coinsurance	Physician Office Copayments are applied rather than the In-Network Copayment listed if medical supplies, Durable Medical Equipment or Appliances are obtained in an In-Network Physician's Office. Pre-certification may be required.
	Hospice service	No Cost Share	**30%** Coinsurance	--------none--------
If your child needs dental or eye care	Eye exam	**$15** Copay/Visit	**30%** Coinsurance	Coverage is for vision exam only. Consult your formal contract of coverage. Costs may vary by site of service. You should refer to your formal contract of coverage for details. In-Network benefit applies for Routine Vision Screening. Vision benefit is available.
	Glasses	Not Covered	Not Covered	Vision benefit is available.
	Dental check-up	Not Covered	Not Covered	--------none--------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Routine foot care (Unless you have been diagnosed with diabetes. Consult your formal contract of coverage.)
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Bariatric surgery
- Chiropractic care
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide
- Private-duty nursing
- Routine eye care (Adult) (Coverage is for vision exam only. Consult your formal contract of coverage.)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-418-1112. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

Anthem BlueCross BlueShield
ATTN: Appeals
P.O. Box 105568
Atlanta, GA 30348-5568

Ohio Department of Insurance
50 West Town Street,
Third Floor, Suite 300
Columbus, OH 43215
800-686-1526 or 614-644-2673

Or Contact:

Department of Labor's Employee Benefits
Security Administration at
1-866-444-EBSA (3272) or
www.dol.gov/ebsa/healthreform

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage**.

Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíílkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $7,160
- **Patient pays:** $380

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$100
Copays	$50
Coinsurance	$60
Limits or exclusions	$170
Total	**$380**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $2,260
- **Patient pays:** $3,140

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$100
Copays	$80
Coinsurance	$30
Limits or exclusions	$2,930
Total	**$3,140**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.