Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Plan: Truman State University-Anthem Blue Access PPO

Your Network: Blue Access

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$750 person / $1,500 family	$1,500 person / $3,000 family
Out-of-Pocket Limit	$2,500 person / $5,000 family	$6,000 person / $12,000 family
The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.		
Preventive Care / Screening / Immunization	No charge	50% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit *When Allergy injections are billed separately by network providers, the member is responsible for a $10 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$25 copay per visit deductible does not apply	50% coinsurance after deductible is met
Specialist Care Visit *When Allergy injections are billed separately by network providers, the member is responsible for a $10 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$35 copay per visit deductible does not apply	50% coinsurance after deductible is met
Prenatal and Post-natal Care	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	$25 copay per visit deductible does not apply	50% coinsurance after deductible is met
Preferred On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	$10 copay per visit deductible does not apply	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Other Participating Provider On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	$25 copay per visit deductible does not apply	50% coinsurance after deductible is met
Chiropractic Services *Coverage is limited to 26 visits per benefit period.*	$25 copay per visit deductible does not apply	50% coinsurance after deductible is met
Other Services in an Office:		
Allergy Testing	$10 copay	50% coinsurance after deductible is met
Chemo/Radiation Therapy - PCP	$25 copay per visit deductible does not apply	50% coinsurance after deductible is met
Chemo/Radiation Therapy - Specialist	$35 copay per visit deductible does not apply	50% coinsurance after deductible is met
Dialysis/Hemodialysis	$35 copay per visit deductible does not apply	50% coinsurance after deductible is met
Prescription Drugs - *Dispensed in the office*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Diagnostic Services **Lab:**		
Office	No charge	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
X-Ray:		
Office	No charge	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging:		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care *When Allergy injections are billed separately by network providers, the member is responsible for a $10 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$50 copay per visit deductible does not apply	Covered as In-Network
Emergency Room Facility Services *Copay waived if admitted.*	$200 copay per visit deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	$200 copay per visit deductible does not apply	Covered as In-Network
Ambulance	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	$25 copay per visit deductible does not apply	50% coinsurance after deductible is met
Facility Visit:		
Facility Fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Surgery		
Facility Fees:		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):		
Facility Fees Coverage for Inpatient physical medicine and rehabilitation including day rehabilitation programs is limited to 60 days combined per benefit period. Limit is combined In-Network and Non-Network.	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Human Organ and Tissue Transplants *Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.*	No charge	30% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Recovery & Rehabilitation **Home Health Care** *Coverage is limited to 100 visits per benefit period. Limit is combined In-Network and Non-Network. Private duty nursing limited to 70 visits per benefit period*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services: Office *Coverage for Physical and Occupational Rehabilitation and Habilitation therapy is limited to 44 visits combined per benefit period. Limit includes manipulative treatment when performed by someone other than a chiropractor. Speech Therapy has no visit limit. Benefit limit does not apply to Applied Behavioral Analysis. Benefit limit does not apply when performed as part of Early Intervention.*	$35 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital *Coverage for Physical and Occupational Rehabilitation and Habilitation therapy is limited to 44 visits combined per benefit period. Limit includes manipulative treatment when performed by someone other than a chiropractor. Speech Therapy has no visit limit. Benefit limit does not apply to Applied Behavioral Analysis. Benefit limit does not apply when performed as part of Early Intervention.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation Office *Coverage is limited to 36 visits per benefit period.*	$35 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital *Coverage is limited to 36 visits per benefit period.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Pulmonary rehabilitation Office Coverage is limited to 20 visits per benefit period.	$35 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital Coverage is limited to 20 visits per benefit period.	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage is limited to 100 days per benefit period. Limit is combined In-Network and Non-Network.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospice	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Durable Medical Equipment	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out of Pocket	$2,000 person/ $3,000 family	Combined with medical
Prescription Drug Coverage *National with R90* *Essential Drug List* *This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs.*		
Tier 1 - Typically Generic *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$15 copay per prescription, deductible does not apply (retail) and $30 copay per prescription, deductible does not apply (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$30 copay per prescription, deductible does not apply (retail) and $60 copay per prescription, deductible does not apply (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$60 copay per prescription, deductible does not apply (retail) and $120 copay per prescription, deductible does not apply (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Tier 4 - Typically Specialty (brand and generic) *30 day supply (retail pharmacy). 30 day supply (home delivery).*	20% coinsurance up to $200 per prescription, deductible does not apply (retail and home delivery)	Not covered
Tier 5-Typically Specialty (brand and generic)-Non Preferred *Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program). No Coverage for non-formulary drugs.*	20% coinsurance up to $250 per prescription, deductible does not apply (retail and home delivery)	Not covered

Notes:

- Dependent age: to end of the year in which the child attains age 26.
- 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.
- All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (including Non-Network Human Organ and Tissue Transplant (HOTT) Services).
- No charge 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.
- If your plan includes out-of-network benefits, In-network and out-of-network deductibles, copayments, coinsurance and out-of-pocket maximum amounts are separate and do not accumulate toward each other.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under “Outpatient Facility Services” which is generally coinsurance or coinsurance after your deductible is met.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.