Your Summary of Benefits

Anthem BlueCross BlueShield

Mahoning County School Employees Insurance Consortium
Blue Access® (PPO)
Effective 07/01/2017

Covered Benefits	Network	Non-Network
Deductible (Single/Family)	$300/$600	$600/$1,200
Coinsurance Limit (Single/Family)	$500/$1,000	$1,250/$2,500
Out-of-Pocket Limit (Single/Family)(includes deductible, medical & Rx copayments and coinsurance)	$7,150/$14,300	Unlimited
Physician Home and Office Services (PCP/SCP) **Primary Care Physician (PCP)/** **Specialty Care Physician (SCP)**	$10/$25	30%
Including Office Surgeries and allergy serum:		
• allergy injections (PCP and SCP)	10%	30%
• allergy testing	10%	30%
• MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds and pharmaceutical products	10%	30%
Preventive Care Services		
• Services included but not limited to: Routine medical exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, and Hearing screenings.	No cost share	30%
Emergency and Urgent Care		
Emergency Room Services	$100/10%	$100/10%
• **facility/other covered services** (copayment waived if admitted)		
Urgent Care Center Services	$25	30%
• MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, Non-maternity related Ultrasounds and pharmaceutical products	10%	30%
• Allergy injections	10%	30%
• Allergy testing	10%	30%
Inpatient and Outpatient Professional Services	10%	30%
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		
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Inpatient Facility Services (Network/Non-Network combined) Unlimited days except for: • Unlimited days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) • 120 days for skilled nursing facility	10%	30%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	10%	30%
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 90 visits (excludes IV Therapy) (Network/Non-Network combined) • Durable Medical Equipment • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	10% 10% 10%	30% 30% 10%
Outpatient Therapy Services (Combined Network & Non-Network limits) • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: • Cardiac Rehabilitation Unlimited • Pulmonary Rehabilitation Unlimited • Physical Therapy: 30 visits • Occupational Therapy: 30 visits • Manipulation Therapy: 36 visits • Speech therapy: 20 visits	 10% 10%	 30% 30%
Accidental Dental: Unlimited per accident (Network and Non-network combined)	Copayments/Coinsurance based on setting where covered services are received	30%
Behavioral Health: **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	Benefits provided in accordance with Federal Mental Health Parity	30%
Human Organ and Tissue Transplants • Acquisition and transplant procedures, harvest and storage.	10%	30%

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Prescription Drugs **Network Tier structure equals-** **(Generic, Brand Formulary, Brand Non formulary, Specialty)**		
○ **Network Retail Pharmacies:** Up to 30 days: Up to 90 days:	 $5/$25/$50/$100 (Specialty) $12.50/$62.50/$125/Specialty N/A	 25%
○ **Home Delivery Service:** (90-day supply)	$12.50/$62.50/$125/ $100(Specialty 30 day supply)	Not covered
** Member may be responsible for additional cost when not selecting the available generic drug.		
** Prilosec OTC/omeprazole	No cost share	
**Medicare Rx - Wrap		

Notes:

- All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum.
- Deductible(s) apply to covered medical services listed with a percentage (%) coinsurance, including 0%.
- Network and Non-network deductibles, copayments, coinsurance and out-of-pocket maximums do 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.
- No cost share (NCS) 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.
- Live Health Online (LHO) is covered at the PCP costshare.
- Benefit period = calendar year
- 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.
- Private Duty Nursing – unlimited visits/Calendar Year
- Plan to cover surgical treatment of morbid obesity, medical, $30,000 Lifetime.
- Plan to cover Rx for surgical treatment of morbid obesity.
- Plan to cover sexual dysfunction, medical and Rx.
- Exclude elective abortions
- 4th qtr. Deductible carryover applies.

[1] We encourage you to review the Schedule of Benefits for limitations.

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, Benefit Booklet, 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 Summary of Benefits
Mahoning County School Employees Insurance Consortium (MCSEIC)
Anthem Dental Complete

Anthem. BlueCross BlueShield

WELCOME TO YOUR DENTAL PLAN!

This benefit summary outlines how your dental plan works and provides you with a quick reference of your dental plan benefits. For complete coverage details, please refer to your employee benefits booklet.

Dental coverage you can count on

Your Anthem dental plan lets you visit any licensed dentist or specialist you want - with costs that are normally lower when you choose one within our large network.

Savings beyond your dental plan benefits - you get more for your money.
You pay our negotiated rate for covered services from in-network dentists even if you exceed your annual benefit maximum.

YOUR DENTAL PLAN AT A GLANCE	In-Network	Out-of-Network
Annual Benefit Maximum Calendar Year		
• Per insured person	$1,000	$1,000
D&P applies to Annual Maximum	Yes	Yes
Orthodontic Lifetime Benefit Maximum		
• Per eligible insured person	$1,500	$1,500
Annual Deductible (The Deductible does not apply to Orthodontic Services)		
• Per insured person Calendar Year	$25	$25
• Family maximum *4th Quarter Deductible Carry Over Applies*	3X Individual	3X Individual
Deductible Waived for Diagnostic/Preventive Services	Yes	Yes
Out-of-Network Reimbursement Options:	90th percentile	

Dental Services	In-Network Anthem Pays:	Out-of-Network Anthem Pays:	Waiting Period
Diagnostic and Preventive Services • Periodic oral exam • Teeth cleaning (prophylaxis) • Bitewing X-rays: 2X per 12 months • Intraoral X-rays	100% Coinsurance	100% Coinsurance	No Waiting Period
Basic Services • Amalgam (silver-colored) Filling • Front composite (tooth-colored) Filling • Back composite Filling, Alternated to Amalgam Benefit • Simple Extractions	80% Coinsurance	80% Coinsurance	No Waiting Period
Endodontics • Root Canal	80% Coinsurance	80% Coinsurance	No Waiting Period
Periodontics • Scaling and root planing	80% Coinsurance	80% Coinsurance	No Waiting Period
Oral Surgery • Surgical Extractions	80% Coinsurance	80% Coinsurance	No Waiting Period
Major Services • Crowns	50% Coinsurance	50% Coinsurance	No Waiting Period
Prosthodontics • Dentures • Bridges • Dental implants Not Covered	50% Coinsurance	50% Coinsurance	No Waiting Period
Prosthetic Repairs/Adjustments	80% Coinsurance	80% Coinsurance	No Waiting Period
Orthodontic Services ·Adults & Dependent Children	60% Coinsurance	60% Coinsurance	No Waiting Periods

This is not a contract; it is a partial listing of benefits and services. All covered services are subject to the conditions, limitations, exclusions, terms and provisions of your employee benefits booklet. In the event of a discrepancy between the information in this summary and the employee booklet, the employee booklet will prevail.

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