Your summary of benefits

Anthem® BlueCross and BlueShield

Your Plan: Newark City Schools-Anthem Blue Access PPO Option with National Rx

Effective 07/01/2020

Your Network: Blue Access

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.

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 Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$500 person / $1,000 family	$1,000 person / $2,000 family
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.*	$1,000 person / $2,000 family	$2,000 person / $4,000 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	40% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit to treat an injury or illness *When Allergy injections are billed separately by network providers, the member is responsible for a $15 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	40% coinsurance after deductible is met

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Specialist Care Visit *When Allergy injections are billed separately by network providers, the member is responsible for a $15 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	40% coinsurance after deductible is met
Prenatal and Post-natal Care *In-Network preventive prenatal services are covered at 100%.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	$25 copay per visit deductible does not apply	40% coinsurance after deductible is met
Preferred On-line Visit	$10 copay per visit deductible does not apply	40% coinsurance after deductible is met
Other Participating Provider On-line Visit	$25 copay per visit deductible does not apply	40% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 24 visits per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	20% coinsurance per visit deductible does not apply	40% coinsurance after deductible is met
Other Services in an Office:		
Allergy Testing	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Chemo/Radiation Therapy Performed by a Primary Care Physician	No Charge	40% coinsurance after deductible is met
Chemo/Radiation Therapy Performed by a Specialist	No Charge	40% coinsurance after deductible is met
Dialysis/Hemodialysis	No charge	40% coinsurance after deductible is met

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Prescription Drugs *For the drugs itself dispensed in the office through infusion/injection.*	No Cost Share	40% coinsurance after deductible is met
Diagnostic Services		
Lab:		
Office	No charge	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
X-Ray:		
Office *Diagnostic X-Ray in an office including Non-maternity Ultrasounds are covered at no charge.*	No charge	40% coinsurance after deductible is met
Outpatient Hospital	No charge	40% coinsurance after deductible is met
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care (Office Setting) *Member cost share for Allergy injections billed separately is $15 copay. If billed with an Urgent Care Facility charge, it will be covered under the UC copayment, there is no additional cost to the member for the injection.*	$75 copay per visit deductible does not apply	40% coinsurance after deductible is met
Urgent care(Facility Setting)		

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Urgent Care: Facility fees	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Urgent Care: Doctor and other services	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$250 copay per visit deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	Covered as In-Network
Ambulance (Air, Ground, and Water)	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	40% coinsurance after deductible is met
Facility visit:		
Facility Fees	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor and Other Services:		

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Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)		
Facility fees (for example, room & board) *Coverage for Inpatient Rehabilitation is limited to 90 days combined per benefit period. Limit is combined In-Network and Non-Network. Benefit includes coverage for Outpatient Rehabilitation program.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Human Organ and Tissue Transplants *Acquisition and transplant procedures, collection and storage. Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.*	No Cost Share	50% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 180 visits per benefit period. Limit is combined In-Network and Non-Network. Limit does not apply to separate Physical or Occupational Therapy limits, when performed as part of Home Health.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Limit is combined for rehabilitative and habilitative services. Coverage for Occupational Therapy is limited to 60 visits per benefit period, Physical Therapy is limited to 60 visits per benefit period and Speech Therapy is limited to 60 visits per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	$25 copay per visit deductible does not apply	40% coinsurance after deductible is met
Outpatient Hospital *Limit is combined for rehabilitative and habilitative services. Coverage for Occupational Therapy is limited to 60 visits per benefit period, Physical Therapy is limited to 60 visits per benefit period and Speech Therapy is limited to 60 visits per benefit period. Limit is combined*	$25 copay per visit deductible does not apply	40% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.		
Cardiac rehabilitation Office *Coverage is limited to 36 visits per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	$25 copay per visit deductible does not apply	40% coinsurance after deductible is met
Outpatient Hospital *Coverage is limited to 36 visits per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	$25 copay per visit deductible does not apply	40% coinsurance after deductible is met
Pulmonary rehabilitation Office *Coverage is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	$25 copay per visit deductible does not apply	40% coinsurance after deductible is met
Outpatient Hospital *Coverage is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	$25 copay per visit deductible does not apply	40% coinsurance after deductible is met
Skilled Nursing Care (in a facility) *Coverage for skilled nursing services is limited to 180 days combined per benefit period. Limit is combined In-Network and Non-Network.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Hospice	No Cost Share	No Cost Share
Durable Medical Equipment	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs after cancer treatment is limited to 1 item per benefit period. Limit is combined In-Network and Non-Network.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met

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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	Combined with medical out of pocket maximum	Combined with medical out of pocket maximum
Prescription Drug Coverage *National Drug List* *This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.*		
Tier 1 - Typically Generic *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$20 copay per prescription, deductible does not apply (retail) and $50 copay per prescription, deductible does not apply (home delivery)	50% coinsurance min $50, deductible does not apply (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$40 copay per prescription, deductible does not apply (retail) and $100 copay per prescription, deductible does not apply (home delivery)	50% coinsurance min $50, deductible does not apply (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.*	$80 copay per prescription, deductible does not apply (retail) and $200 copay per prescription, deductible does not apply (home delivery)	50% coinsurance min $50, deductible does not apply (retail) and Not covered (home delivery)

Your summary of benefits

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) *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.*	$150 copay per prescription, deductible does not apply (retail) and $150 copay per prescription, deductible does not apply (home delivery)	50% coinsurance min $50, deductible does not apply (retail) and Not covered (home delivery)

Your summary of benefits

Notes:

- 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.
- 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 in which the child attains age 26.
- 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.
- Certain diabetic and asthmatic supplies are available at Network pharmacies, diabetic test strips paid same as any other drug.
- 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.
- Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.
- 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 (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).
- No Copayment or Coinsurance applies to certain diabetic and asthmatic supplies when you get them from an In-Network Pharmacy. These supplies are covered as Medical Supplies and Durable Medical Equipment if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance. Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.
- Hospital stay for Maternity Coverage will not be limited to less than 48 hours for a vaginal delivery or 96 hours for a caesarean section.
- PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, geriatrics or any other Network provider as allowed by the plan.
- Urgent Care Facility Copay exclude certain diagnostic test such as MRAs, MRIs, C-Scans, Nuclear Cardiology Imaging Studies, Allergy Testing, and Pharmaceutical injection and drugs.
- Benefit period = plan year
- Private Duty Nursing – unlimited visits/Calendar Year.
- Vision limited services – additional vision services are covered when specifically coded as determination of refraction, routine ophthalmological examination including refraction for new and established patients, and a visual functional screening for visual acuity. No additional ophthalmological services are covered as part of the medical coverage.

Your 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.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (833) 639-1634

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(TTY/TDD: 711)

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It's important we treat you fairly
That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.