

Your Summary of Benefits



Hancock County Government
Blue Access® for Health Savings Accounts
Effective: January 1, 2020

Please note: As we receive additional guidance and clarification from the U.S. Department of Health and Human Services, we may be required to make additional changes to your benefits

Covered Benefits	Network	Non-Network
Deductible Embedded The single deductible applies to the Family deductible. Once the single deductible has been satisfied, benefits for that member are payable subject to coinsurance. Once the family deductible has been satisfied, benefits for the family are payable subject to coinsurance.	Single: \$3,000 Family: \$6,000	Single: \$6,000 Family: \$12,000
Out-of-Pocket Limit	Single: \$3,000 Family: \$6,000	Single: \$12,000 Family: \$24,000
Physician Home and Office Services <ul style="list-style-type: none"> Including Office Surgeries, allergy serum, allergy injections and allergy testing 	0%	30%
Preventive Care Services Services include but are not limited to: Routine Exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Routine Vision and Hearing exams <ul style="list-style-type: none"> Physician Home and Office Visits Other Outpatient Services @ Hospital/Alternative Care Facility 	No copayment/coinsurance	30%
Emergency and Urgent Care <ul style="list-style-type: none"> Emergency Room Services (facility/other covered services) (copayment waived if admitted) Urgent Care Center Services 	0% 0%	0% 30%
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 	0%	30%
Inpatient Facility Services (Network/Non-Network combined) Unlimited days except for: <ul style="list-style-type: none"> 60 days for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) 90 days for skilled nursing facility 	0%	30%

Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc. Independent licensee of the Blue Cross and Blue Shield Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Your Summary of Benefits

Covered Benefits	Network	Non-Network
Outpatient Surgery Hospital/Alternative Care Facility <ul style="list-style-type: none"> Surgery and administration of general anesthesia 	0%	30%
Blue 8.5		
Other Outpatient Services (Network/Non-network combined) 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 (excluding Prosthetic Devices, Limbs and Medical Supplies) Prosthetic Devices Prosthetic Limbs Physical Medicine Therapy Day Rehabilitation programs Hospice Care Ambulance Services 	0%	30%
Accidental Dental Services \$3,000 limit per occurrence (network and non-network combined)	0%	30%
Outpatient Therapy Services (Combined Network & Non-Network limits apply) <ul style="list-style-type: none"> Physician Home and Office Visits Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: <ul style="list-style-type: none"> Physical therapy: 20 visits Occupational therapy: 20 visits Manipulation therapy: 12 visits Speech therapy: 20 visits Cardiac Rehabilitation: 36 visits Pulmonary Rehabilitation: 20 visits 	0%	30%
Behavioral Health Service Mental Illness and Substance Abuse¹: <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. 	0%	30%
Human Organ and Tissue Transplants <ul style="list-style-type: none"> Acquisition and transplant procedures, harvest and storage. 	0%	30%

Your Summary of Benefits

Covered Benefits	Network	Non-Network
Prescription Drugs - Anthem National Drug List <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 Specialty medications are limited up to a 30 day supply regardless of whether they are retail or mail service. Medicare Rx - Wrap	0% 0%	30% ² Not covered
Lifetime Maximum (Combined Network and Non-network)³	Unlimited	Unlimited

Notes:

- All medical and drug cost shares, deductibles and percentage (%) coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).
- Deductible(s) apply to covered services listed with a percentage (%) coinsurance, including 0%.
- Deductible applies to all prescription drug expenses for Rx plans. Once the deductible is met the appropriate copayment/ coinsurance applies. Copayments/coinsurance accumulate to the Medical OOP max. Once the Medical OOP max is met, no additional cost share applies.
- Once the family deductible is satisfied by either one member or all members collectively, then the additional percentage coinsurance will be required before the family out-of-pocket is satisfied. Does not apply to embedded deductible plans.
- Network and Non-network **Deductible**, 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
- 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.
- No Cost Share (NCS): No deductible/copayment/coinsurance up to the maximum allowable amount.
- Live Health Online (LHO) is covered at the PCP cost share.
- 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 – limited to 82 visits/Calendar Year and 164 visits/lifetime.
- Elective abortions not covered unless otherwise noted in your Certificate of Coverage.
- Wigs limited to 1 per benefit period

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

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

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 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.

This benefit overview is for illustrative purposes and some content may be pending Indiana Department of Insurance approval.

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