CEBCO: Champaign County Plan 1a
Blue Access (PPO)

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2015 - 12/31/2015
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 at www.anthem.com or by calling 1-855-603-7982.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$250** Single/**$500** Family for Network Providers. **$500** Single/**$1,000** Family for Non-Network Providers. Network Provider and Non-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. **$1,500** Single/**$3,000** Family for Network Providers. **$3,000** Single/**$6,000** Family for Non-Network Providers. Network Provider and Non-Network Provider out-of-pocket are separate and do not count towards each other. This plan has a separate Out-of-Pocket Maximum of **$2,500** Single/**$5,000** Family combined for Retail and Mail Order for Network and Non-Network Prescription Drugs.	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 cost share options, Non-Network Human Organ and Tissue Transplant (HOTT) Services, Premiums,	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.

	Balance-billed charges and Health care this plan doesn't cover.	
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. See www.anthem.com or call 1-855-603-7982 for a list of Network Providers.	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 6. 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 Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-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	For in-network: Allergy injections - $5 Allergy testing, MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies & non-maternity related Ultrasounds – 10% coinsurance Routine & non-routine mammograms (regardless of outpatient setting), diabetic education (regardless of outpatient setting), & certain medical nutritional therapy – No Cost share
	Specialist visit	**$25** Copay/Visit	**30%** Coinsurance	--------none--------
	Other practitioner office visit	Manipulative Therapy **$25** Copay/Visit Acupuncturist Not Covered	Manipulative Therapy **30%** Coinsurance Acupuncturist Not Covered	Manipulative Therapy Coverage is limited to 12 visits per Benefit Period combined Network and Non-Network Providers. Costs may vary by site of service. You should refer to your formal contract of coverage for details.
	Preventive care/screening/immunization	No Cost Share	**30%** Coinsurance	--------none--------
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office **10%** Coinsurance X-Ray – Office **10%** Coinsurance	Lab – Office **30%** Coinsurance X-Ray – Office **30%** Coinsurance	Lab – Office Costs may vary by site of service. You should refer to your formal contract of coverage for details. X-Ray – Office 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 a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	**10%** Coinsurance	**30%** Coinsurance	--------none--------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic Drugs	**$10** Copay/Prescription for Retail **$20** Copay/Prescription for Mail Order	Not Covered	Retail Pharmacy – 30-day supply Mail Order Pharmacy – 90-day supply $2,500/$5,000 Out of Pocket Maximum (Single/Family) for Retail/Mail Order Combined Generic Incentive Plan Prior Authorization: some drugs may require a prior authorization (preauthorization). If necessary, prior authorization (preauthorization) is not obtained, the drug may not be covered. Specialty medications must be obtained via our specialty pharmacy network in order to receive network level benefits. Specialty medications are limited to a 30-day supply regardless of whether they are retail or home delivery.
	Brand Name Formulary Drugs	**$25** Copay/Prescription for Retail **$50** Copay/Prescription for Mail Order	Not Covered	
	Brand Name Non-formulary Drugs	**$40** Copay/Prescription for Retail **$80** Copay/Prescription for Mail Order	Not Covered	
	Tier 4 -Typically Specialty Drugs	Follows retail co-pays	Not Covered	--------none--------
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	Emergency room services	**$150** Copay/Visit	**$150** Copay/Visit	If admitted, ER Copay is waived.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
immediate medical attention	Emergency medical transportation	**10%** Coinsurance	**10%** Coinsurance	--------none--------
	Urgent care	**$35** Copay/Visit	**$35** Copay/Visit	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	**10%** Coinsurance	**30%** Coinsurance	Unlimited days except for 60 days network/ non-network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis).
	Physician/surgeon fee	**10%** Coinsurance	**30%** Coinsurance	--------none--------
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	--------none--------
	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	--------none--------
	Substance use disorder inpatient services	**10%** Coinsurance	**30%** Coinsurance	--------none--------
If you are pregnant	Prenatal and postnatal care	**10%** Coinsurance	**30%** Coinsurance	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.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Delivery and all inpatient services	**10%** Coinsurance	**30%** Coinsurance	Applies to inpatient facility. Other cost shares may apply depending on the services provided.
If you need help recovering or have other special health needs	Home health care	**10%** Coinsurance	**30%** Coinsurance	Coverage is limited to 90 visits per Benefit Period combined Network and Non-Network Providers. Excludes IV therapy
	Rehabilitation services	**$25** Copay/Visit	**30%** Coinsurance	Coverage is limited to 30 visits per Benefit Period each for Physical Therapy and Occupational Therapy combined Network and Non-Network Providers. Coverage is limited to 20 visits per Benefit Period for Speech Therapy combined Network and Non-Network Providers. Costs may vary by site of service. You should refer to your formal contract of coverage for details.
	Habilitation services	**10%** Coinsurance	**30%** Coinsurance	Habilitation visits count towards your Rehabilitation limit.
	Skilled nursing care	**10%** Coinsurance	**30%** Coinsurance	Coverage is limited to 90 days per Benefit Period combined Network and Non-Network Providers.
	Durable medical equipment	**10%** Coinsurance	**30%** Coinsurance	--------none--------
	Hospice service	**10%** Coinsurance	**10%** Coinsurance	--------none--------
If your child needs dental or eye care	Eye exam	No Cost Share	**30%** coinsurance after deductible	Vision screening part of preventive care benefit
	Glasses	Not Covered	Not Covered	--------none--------
	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 & Child)
- Hearing aids
- Infertility treatment
- Long-term care
- Routine foot care
- 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 (Coverage is limited to 82 visits per Benefit Period and 164 visits per Lifetime.)
- Routine eye care (Adult)

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 1-855-603-7982. 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 ei dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíiłkiid. Éí 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:** $6,470
- **Patient pays:** $1,070

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	$250
Copays	$20
Coinsurance	$650
Limits or exclusions	$150
Total	**$1,070**

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,420
- **Patient pays:** $980

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	$250
Copays	$550
Coinsurance	$100
Limits or exclusions	$80
Total	**$980**

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.