

# Your Anthem Benefits



**Truman State University**  
**Blue Access<sup>SM</sup> Plan B**  
**Summary of Benefits, Effective 1/1/2009**

Covered Benefits	Network	Non-Network
<b>Deductible (Single/Family)</b>	\$1,500/\$3,000	\$3,000 / \$6,000
<b>Out-of-Pocket Limit (Single/Family)</b>	\$4,000 / \$10,000	\$10,000 / \$20,000
<b>Physician Home and Office Services (PCP/SCP)</b> Primary Care Physician (PCP)/Specialty Care Physician (SCP) Including Office Surgeries and allergy serum: <ul style="list-style-type: none"> <li>allergy injections (PCP and SCP)</li> <li>allergy testing</li> <li>routine and non-routine mammograms (regardless of outpatient setting)</li> <li>diabetic self management training (regardless of outpatient setting)</li> <li>certain medical nutritional therapy (regardless of outpatient setting)</li> <li>MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies and non-maternity related Ultrasounds</li> </ul>	20%	50%
<b>Preventive Care Services</b> Services include but are not limited to: Routine Exams, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Routine Vision and Hearing exams <ul style="list-style-type: none"> <li>Physician Home and Office Visits (PCP/SCP)</li> <li>Other Outpatient Services @ Hospital/Alternative Care Facility</li> <li>Immunizations through age 5</li> </ul>	No copayment /coinsurance No copayment/coinsurance No copayment/coinsurance	50% 50% No Copayment/coinsurance
<b>Emergency and Urgent Care</b> <ul style="list-style-type: none"> <li><b>Emergency Room Services @ Hospital (facility/other covered services) (copayment waived if admitted)</b></li> <li><b>Urgent Care Center Services</b></li> </ul>	20%	20%
<b>Inpatient and Outpatient Professional Services</b> Include but are not limited to: <ul style="list-style-type: none"> <li>Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams</li> </ul>	20%	50%
<b>Inpatient Facility Services</b> Unlimited days except for: <ul style="list-style-type: none"> <li>60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)</li> <li>100 days Network/Non-Network combined for skilled nursing facility</li> </ul>	20%	50%
<b>Outpatient Surgery Hospital/Alternative Care Facility</b> <ul style="list-style-type: none"> <li>Surgery and administration of general anesthesia</li> </ul>	20%	50%
<b>Other Outpatient Services (including but not limited to):</b> <ul style="list-style-type: none"> <li>Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds, and other diagnostic outpatient services.</li> <li>Home Care Services (Network/Non-network combined) 100 visits (excludes IV Therapy)</li> <li>Durable Medical Equipment and Orthotics (Network/Non-network combined) \$5,000 benefit maximum (excluding Prosthetic Devices and Medical Supplies)</li> <li>Prosthetic Devices \$5,000 benefit maximum</li> <li>Physical Medicine Therapy Day Rehabilitation programs</li> <li>Hospice Care</li> <li>Ambulance Services</li> </ul>	20%	50%
	20%	20%

Covered Benefits	Network	Non-Network
<b>Outpatient Therapy Services</b> <b>(Combined Network &amp; Non-Network limits apply)</b> <ul style="list-style-type: none"> <li>Physician Home and Office Visits (PCP/SCP)</li> <li>Other Outpatient Services @ Hospital/Alternative Care Facility</li> </ul> Limits apply to: <ul style="list-style-type: none"> <li>Physical/Manipulation therapy excluding Chiropractic Services: 24 visits</li> <li>Occupational therapy: 20 visits</li> <li>Chiropractic Services: 26 visits</li> <li>Speech therapy: 20 visits</li> </ul>	\$20% 20%	50% 50%
<b>Behavioral Health Services: (Network and Non-Network)</b> <b>Mental Health and Substance Abuse</b> <ul style="list-style-type: none"> <li>Inpatient Facility Services</li> <li>Physician Home and Office Visits (PCP/SCP)</li> <li>Other Outpatient Services @ Hospital/Alternative Care Facility</li> </ul> <b>Substance Abuse limits</b> <ul style="list-style-type: none"> <li><b>Inpatient:</b> 30 days/6 detox</li> <li><b>Outpatient Facility:</b> 20 visits</li> <li><b>Outpatient Office Visits:</b> 20 visits</li> </ul> <i>(Substance Abuse rehabilitation programs are limited to 10 episodes per lifetime Network and Non-Network combined.)</i>	20% 20% 20%	50% 50% 50%
<b>Human Organ and Tissue Transplants<sup>1</sup></b> <ul style="list-style-type: none"> <li>Acquisition and transplant procedures, harvest and storage.</li> </ul>	No copayment/coinsurance	30%
<b>Prescription Drugs<sup>2</sup></b> <ul style="list-style-type: none"> <li><b>Network Retail Pharmacies:</b> (30-day supply) Includes diabetic test strip</li> <li><b>Anthem Rx Direct Mail Service:</b> (90-day supply) Includes diabetic test strip</li> </ul> <b>Medicare Rx - Wrap</b> <b>Specialty Medications</b> must be obtained via our Specialty Pharmacy network in order to receive network level benefits.	\$15/ \$30/ \$60 / 20% with a \$200 maximum 20% up to \$5000 out of pocket  \$30 / \$60 / \$120 / 20% with a \$200 maximum 20% up to \$5000 out of pocket	50% (min \$45) <sup>3</sup>  Not covered
<b>Lifetime Maximum (Combined Network and Non-network)<sup>4</sup></b>	\$1 million	\$1 million

**Notes:**

- Flat dollar copayments and Non Network Human Organ and Tissue Transplants are excluded from the out-of-pocket limits. Also Prescription Drug deductibles/copayments/coinsurance are excluded from the out-of-pocket limits.
- Deductible(s) apply only to covered medical services listed with a percentage (%) coinsurance. However, the deductible does not apply to Emergency Room Services where a copayment and a percentage (%) coinsurance applies.
- Network and Non-network deductibles, copayments, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- Dependent Age: to the end of the calendar year which the child attains age 25
- Specialist copayment is applicable to all Specialists excluding General Physicians, Internist, Pediatricians, OB/GYN's and Geriatrics or any other Network Provider as allowed by the plan.
- Physicians Home and office visit copayment applies if the office visit is billed with allergy injections.
- No copayment/coinsurance 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.
- Certain diabetic and asthmatic supplies have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies, except diabetic test strips.
- Benefit period = calendar year

<sup>1</sup> Kidney and cornea are treated the same as any other illness and subject to the medical benefits.

<sup>2</sup> If applicable, all prescription drug expenses except tier 1, (Network/Non-network, Retail/Mail-service combined) apply to the per individual RX deductible. Once the RX deductible is met, the appropriate copayment applies. Also if applicable, the Prescription Drug out of pocket maximum applies to Network Retail and Mail-Service combined.

<sup>3</sup> Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.

<sup>4</sup> Prescription Drugs do not accumulate toward the Medical Lifetime Maximum (if applicable). However, once the Medical Lifetime Maximum is met (if applicable), no additional Prescription Drug claims will be paid.

**Precertification:**

- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.

**Pre-existing Exclusion Period:**

We will not provide benefits for services, supplies or charges for any pre-existing condition for the time period specified below (subject to HIPAA portability requirements):  
12 months after the member's enrollment date

A pre-existing condition is a condition (mental or physical) which was present and for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the member's enrollment date. Pregnancy and domestic violence are not considered a pre-existing condition. Genetic information may not be used as a condition in the absence of a diagnosis.

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.

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