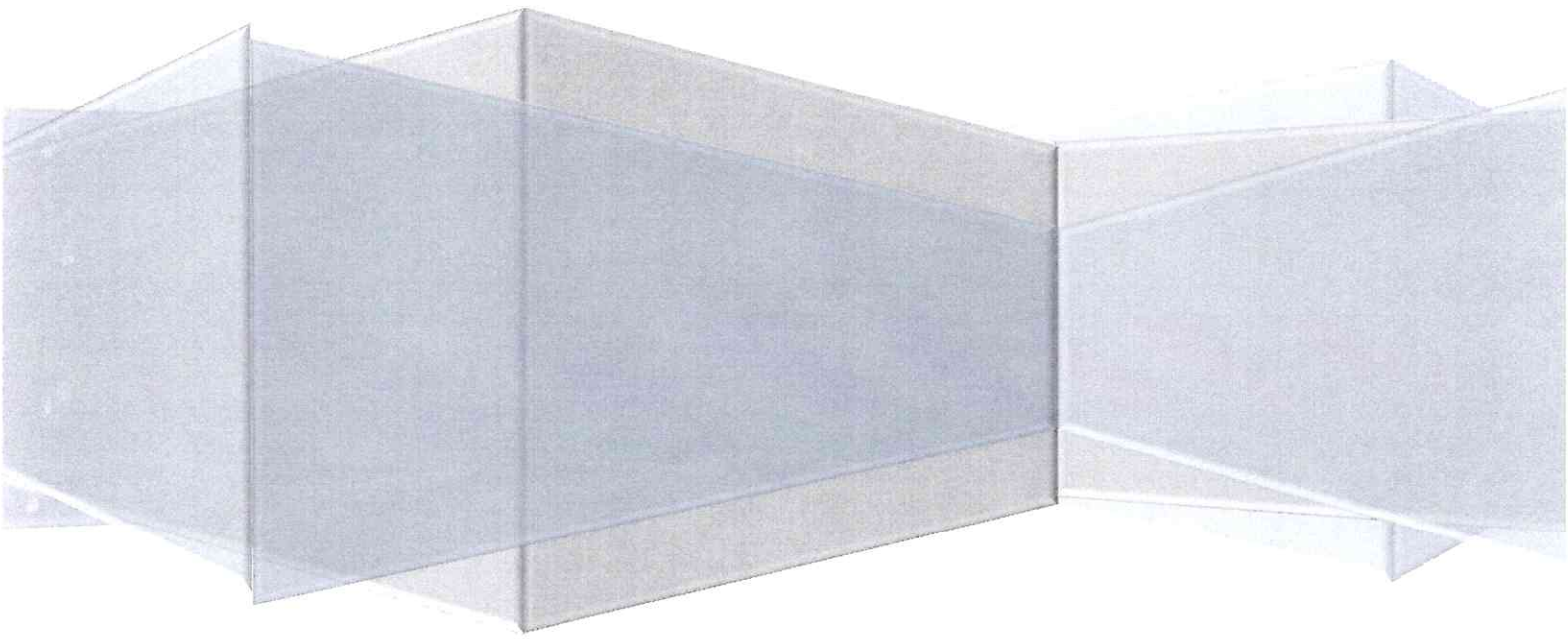
OHIO COUNTY FISCAL COURT

HEALTH INSURANCE

Effective July 1, 2020 thru June 30, 2021



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Need Help With Your Benefits?

For *faster* and *confidential* help,
Please contact Anthem or HRI ***first:***

Anthem

Group Member Services: **1-888-650-4047**
or
Register online at MyAnthem under the Members Link at:
www.Anthem.com

HEALTH RESOURCES, INC.

dental health OPTIONS

Customer Care for Dental or Stand Alone Davis Vision
1-800-727-1444
or
Register online under the Members Link at:
www.hri-dho.com

If unable to resolve the issue after contacting Anthem or HRI, then contact:

Peel & Holland
Insurance ▪ Risk Consulting ▪ Employee Benefits

Marla Knight-Dutille
Employee Benefits Consultant
Mknight-Dutille@Peelholland.com
Ph: 270-253-3294
Fax: 815-846-5879

Meghann Lillard, *Account Manager* ***Kelli Jo Thurmond,*** *Administrative Acct Manager*

Ohio County Fiscal Court
2020 Plan Comparisons

		Core Renewal Embedded HSAPE06	Buy-Up Renewal Embedded P29E2	Alternate Renewal Embedded P22E2
		IN-NETWORK SUMMARY OF BENEFITS		
Lifetime Max		Unlimited	Unlimited	Unlimited
HRA Dollars		$500	N/A	N/A
Deductible (Individual/Family)		$3000/$6000	$2500/$5000	$1500/$3000
Out of Pocket Max (Individual/Family		$5000/$10000	$6600/$13200	$6500/$13000
Coinsurance		80/20	80/20	80/20
Inpatient Services		80/20	80/20	80/20
Outpatient Surgery		80/20	80/20	80/20
ER Services		80/20	$250/20%	$250/20%
PCP Visit		80/20	$25	$25
Specialist		80/20	$50	$50
Preventative		Paid 100%	Paid 100%	Paid 100%
Retail Drugs 30 Day Supply		80/20	10/35/75/25%	10/35/75/25%

Once Max out of pocket is reached all services are paid 100% by Anthem
Healthcare Reform requires all policies to cover preventative with no cost share.
This is for comparison purposes only and not binding. Please refer to Anthem's pricing and benefit summary
All copays apply to the Max out of pocket INCLUDING RX.

FSA Money

Why do it.....

If you have medical deductions that you know you will be out this is a good way to pay for that tax free.

Example: **You take 3 medicines and the deductible costs you $55 per month. You know you will be out this money. That is $660 per year.**

You can have $13.75 deducted from your paycheck weekly TAX FREE. This amount will be loaded onto a card and made available for you to use at your pharmacy.

Example: **You have dental work coming up that will cost $1500.**

You can have $31.25 deducted from your paycheck weekly TAX FREE. This amount will be loaded onto a card and made available for you to use at the dentist office.

Example: **You and your spouse or child will be needed new glasses. Your deductible will be $488.**

You can have $10.17 deducted from your paycheck weekly TAX FREE. This amount will be loaded onto a card and made available for you to use at the eye doctor's office.

FSA eligible items and expenses list

Form: FSAITEMLIST06042013

F E B C O

Benefits Consultants

A

Abortion
Acetaminophen - *Prescription required to be reimbursed*
Acne Treatment *(Example: Proactive, Stridex) – Prescription required to be reimbursed*
Acne Laser Treatment
Acupuncture
Air Conditioner – Requires a Letter of Medical Necessity to be reimbursed
Air Purifier - Requires a Letter of Medical Necessity to be reimbursed
Alcoholism Treatment
Allergy Medications & Patches - *Prescription required to be reimbursed*
Allergy Nasal Sprays - *Prescription required to be reimbursed*
Alternative Dietary Substitutes - Requires a Letter of Medical Necessity to be reimbursed
Alternative Drugs & Medicines - Requires a Letter of Medical Necessity to be reimbursed
Alternative Healers - Requires a Letter of Medical Necessity to be reimbursed
Ambulance
Antacids & Heartburn Relief - *Prescription required to be reimbursed*
Antibiotic Creams & Ointments, Hemorrhoid Preparations - *Prescription required to be reimbursed*
Anti-Diarrheal *(Example: Alka-Seltzer, Milk of Magnesia)* - *Prescription required to be reimbursed*
Anti-Itch & Hydrocortisone Creams - *Prescription required to be reimbursed*
Arch & Insole Supports - *Prescription required to be reimbursed*
Arthritis Pain-Relief - *Prescription required to be reimbursed*
Artificial Limbs
Artificial Teeth
Aspirin - *Prescription required to be reimbursed*
Asthma Treatments
Automobile Modifications - Requires a Letter of Medical Necessity to be reimbursed

B

Back Supports
Bandages
Behavioral Modification Programs - Requires a Letter of Medical Necessity to be reimbursed
Birth Control Pills
Birthing Classes - Requires a Letter of Medical Necessity to be reimbursed
Birthing Tub
Blood Pressure Monitoring Devices
Blood Sugar Test Kits & Test Strips
Blood Test
Body Scans
Braille Books & Magazines

B (Cont.)

Breast Pumps
Breast Reconstruction Surgery Following Mastectomy

C

Calamine Lotion - *Prescription required to be reimbursed*
Carpal Tunnel Wrist Supports
Cervical Pillow - Requires a Letter of Medical Necessity to be reimbursed
Chelation Therapy
Chiropractors
Chondroitin/Glucosamine - *Prescription required to be reimbursed*
Christian Science Practitioners
Circumcision
Cold Medicines - *Prescription required to be reimbursed*
Cold/Hot Packs
Condoms
Contact Lenses, Materials & Equipment
Contraceptives
Counseling *(Marriage and couples counseling are ineligible)* - Requires a Letter of Medical Necessity to be reimbursed
Co-Payments
Crowns & Bridges
Crutches

D

Deductibles
Dental Care
Dental Sealants
Dental Treatments
Dental X-Rays
Dentures
Diabetic Supplies
Diagnostic Items & Services
Diaper Rash Creams - *Prescription required to be reimbursed*
Diarrhea Medicine - *Prescription required to be reimbursed*
Dietary Supplements - Requires a Letter of Medical Necessity to be reimbursed
Drug Addiction Treatment
Drug Overdose Treatment
Dyslexia - Requires a Letter of Medical Necessity to be reimbursed

E

Ear Drops & Wax Removal - *Prescription required to be reimbursed*
Ear Plugs - Requires a Letter of Medical Necessity to be reimbursed
Egg Donor Fees
Exercise Equipment & programs - Requires a Letter of Medical Necessity to be reimbursed
Eye Examinations

F

Fertility Treatments

F (Cont.)

Fiber Supplements - Requires a Letter of Medical Necessity to be reimbursed
First Aid Kits
Flu Shots
Fluoridation Device

G

Glucose monitoring equipment
Guide Dog: Other Aid Animals

H

Health Club Fees - Requires a Letter of Medical Necessity to be reimbursed
Hearing Aids & Its Batteries
Hearing Exams
Hemorrhoid Treatments - *Prescription required to be reimbursed*
Home Care - Requires a Letter of Medical Necessity to be reimbursed
Home Diagnostic Tests or Kits *(Example: Blood pressure, Cholesterol, HIV)*
Home Improvements *(Example: Wheelchair Ramp, Widening Doorways)* **- Requires a Letter of Medical Necessity to be reimbursed**
Homeopathic Medicines - *Prescription required to be reimbursed*
Hormone Replacement Therapy - Requires a Letter of Medical Necessity to be reimbursed
Hospital Services
Humidifier - Requires a Letter of Medical Necessity to be reimbursed

I

Ibuprofen - *Prescription required to be reimbursed*
Immunizations
Incontinence Supplies *(example: Depends and Serenity Pads)*
Infertility Treatments
Insulin

J

Joint-Support Bandages & Hosiery

K

L

Laboratory Fees
Lactation Consultant - Requires a Letter of Medical Necessity to be reimbursed
Lamaze Classes *(For mothers only)* **- Requires a Letter of Medical Necessity to be reimbursed**
Laser Eye Surgery
Laxatives - *Prescription required to be reimbursed*
Lead-Based Paint Removal - Requires a Letter of Medical Necessity to be reimbursed
Learning Disability Instructional Fees

M

Massage Therapy - Requires a Letter of Medical Necessity to be reimbursed
Mastectomy-Related Special Bras
Medical Alert Bracelet or Necklace
Medical Monitoring & Testing Devices
Medical Records Charges
Menstrual Pain Relievers - *Prescription required to be reimbursed*
Mileage for Medical Appointment
Mineral Supplements - Requires a Letter of Medical Necessity to be reimbursed
Morning After Contraceptive Pills
Motion Sickness Treatment - *Prescription required to be reimbursed*

N

Nutritional & Dietary Supplements - Requires a Letter of Medical Necessity to be reimbursed
Nasal Strips or Sprays - *Prescription required to be reimbursed*
Nicotine Gum or Patches - *Prescription required to be reimbursed*

O

Occlusal Guards to Prevent Teeth Grinding
Operations
Optometrist
Organ Donors/Transplants
Orthodontia
Orthodontia/Braces
Orthopedic Shoes & Inserts - Requires a Letter of Medical Necessity to be reimbursed
Osteopath Fees
Ovulation Monitor
Oxygen

P

Physical Exams
Physical Therapy
Pregnancy Test Kits
Prenatal Vitamins - Requires a Letter of Medical Necessity to be reimbursed
Prosthesis
Psychiatric Care
Psychologist - Requires a Letter of Medical Necessity to be reimbursed

Q

R

Radial Keratotomy
Retin-A *(For Treatment of Acne)* - *Prescription required to be reimbursed*
Rubber Gloves - Requires a Letter of Medical Necessity to be reimbursed
Rubbing Alcohol

S

Screening Tests
Shampoo Treatments Relating to Treatment of Lice
Sleep Aids - *Prescription required to be reimbursed*
Sleep Deprivation Treatment
Smoking Cessation Medications
Smoking Cessation Programs
Spermicidal Foam
Splints/Casts
Sterilization Procedures
Sun Glasses *(Prescription Lenses Only)*
Sunburn Creams & Ointments - *Prescription required to be reimbursed*
Syringes

T

Taxes on Medical Services & Products
Telephone for Hearing-Impaired Persons
Television for Hearing-Impaired Persons
Therapy
Thermometers
Tooth & Mouth Pain Relief

U

Ultrasounds

V

Vaccinations
Vaporizers - Requires a Letter of Medical Necessity to be reimbursed
Vasectomy
Vasectomy Reversal
Viagra
Vitamins - Requires a Letter of Medical Necessity to be reimbursed

W

Walkers
Wart Removal Medication
Weight Loss Programs and/or prescribed drugs - Requires a Letter of Medical Necessity to be reimbursed
Wheelchair

X

X-ray fees

Y & Z

IMPORTANT

NOTICE…….

If you have ANTHEM Insurance you are provided Blue View Vision for you (only). This is provided free.

The $500 HRA card DOES NOT cover vision deductibles.

DAVIS VISION

The only reason to purchase Davis Vision is if you want to cover a family member.

Take care of yourself. Use your preventive care benefits.

Anthem BlueCross BlueShield

Getting regular checkups and exams can help you stay well and catch problems early. It may even save your life.

Our health plans offer the services listed in this preventive care flier at no cost to you.[1] When you get these services from doctors in your plan's network, you don't have to pay anything out of your own pocket. You may have to pay part of the costs if you use a doctor outside the network.

Preventive versus diagnostic care

What's the difference? Preventive care helps protect you from getting sick. Diagnostic care is used to find the cause of existing illnesses. For example, say your doctor suggests you have a colonoscopy because of your age when you have no symptoms. That's preventive care. On the other hand, say you have symptoms and your doctor suggests a colonoscopy to see what's causing them. That's diagnostic care.

Child preventive care

Preventive physical exams

Screening tests:

- Behavioral counseling to promote a healthy diet
- Blood pressure
- Cervical dysplasia screening
- Cholesterol and lipid level
- Depression screening
- Development and behavior screening
- Type 2 diabetes screening
- Hearing screening
- Height, weight and body mass index (BMI)
- Hemoglobin or hematocrit (blood count)
- HPV screening (female)
- Lead testing
- Newborn screening
- Screening and counseling for obesity
- Counseling for those ages 10-24, with fair skin, about ways to lower their risk for skin cancer
- Oral (dental health) assessment when done as part of a preventive care visit
- Screening and counseling for sexually transmitted infections
- Tobacco use: related screening and behavioral counseling
- Vision screening[2] when done as part of a preventive care visit

Immunizations:

- Diphtheria, tetanus and pertussis (whooping cough)
- Haemophilus influenza type b (Hib)
- Hepatitis A and Hepatitis B
- Human papillomavirus (HPV)
- Influenza (flu)
- Measles, mumps and rubella (MMR)
- Meningococcal (meningitis)
- Pneumococcal (pneumonia)
- Polio
- Rotavirus
- Varicella (chickenpox)

Women's preventive care:

- Well-woman visits
- Breast cancer, including exam, mammogram, and, including genetic testing for BRCA 1 and BRCA 2 when certain criteria are met[3]
- Breast-feeding: primary care intervention to promote breast-feeding support, supplies and counseling (female)[4,5]
- Contraceptive (birth control) counseling
- FDA-approved contraceptive medical services provided by a doctor, including sterilization
- Counseling related to chemoprevention for women with a high risk of breast cancer
- Counseling related to genetic testing for women with a family history of ovarian or breast cancer
- HPV screening[5]
- Screening and counseling for interpersonal and domestic violence
- Pregnancy screenings: includes, but is not limited to, gestational diabetes, hepatitis, asymptomatic bacteriuria, Rh incompatibility, syphilis, iron deficiency anemia, gonorrhea, chlamydia and HIV[5]
- Pelvic exam and Pap test, including screening for cervical cancer

The preventive care services listed are recommendations as a result of the Affordable Care Act (ACA, or health care reform law). The services listed may not be right for every person. Ask your doctor what's right for you, based on your age and health condition(s).

This sheet is not a contract or policy with Anthem Blue Cross and Blue Shield. If there is any difference between this sheet and the group policy, the provisions of the group policy will govern. Please see your combined Evidence of Coverage and Disclosure Form or Certificate for Exclusions and Limitations.

43199MUMENABS Rev. 09/15

Your summary of benefits

Anthem

Core Plan

Anthem® BlueCross and BlueShield

Your Plan: Anthem Blue Access PPO HSA Option E6

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.*	$3,000 person / $6,000 family	$9,000 person / $18,000 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.*	$5,000 person / $10,000 family	$15,000 person / $30,000 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	50% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit to treat an injury or illness	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Specialist Care Visit	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Core Plan

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prenatal and Post-natal Care *In-Network preventive prenatal services are covered at 100%.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	20% coinsurance after deductible is met	50% coinsurance after deductible is met
On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 12 visits per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Services in an Office:		
Allergy Testing	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Chemo/Radiation Therapy	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Dialysis/Hemodialysis	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Prescription Drugs *For the drugs itself dispensed in the office through infusion/injection.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Core Plan

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Diagnostic Services		
Lab:		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Lab/Reference Lab	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
X-Ray:		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Core Plan

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency and Urgent Care		
Urgent Care (Office Setting)	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Urgent care(Facility Setting)		
Urgent Care: Facility fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Urgent Care: Doctor and other services	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency Room Facility Services	20% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	Covered as In-Network
Ambulance (Air, Ground, and Water) *Non-emergency non-network Ambulance Services are limited to $50,000 per occurrence.*	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Facility visit:		
Facility Fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Core Plan

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Surgery		
Facility Fees:		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	50% 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 Skilled Nursing, Inpatient Physical Medicine and Rehabilitation including day rehabilitation is limited to 150 days combined per benefit period. Limit is combined In-Network and Non-Network.*	20% coinsurance after deductible is met	50% 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.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Core Plan

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 100 visits per benefit period. Limit is combined In-Network and Non-Network. Limits are combined for home health care and private duty nursing.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 20 visits per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 20 visits per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 20 visits per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 20 visits per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
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.*	20% coinsurance after deductible is met	50% 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.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Pulmonary rehabilitation		

Your summary of benefits

Core Plan

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
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.*	20% coinsurance after deductible is met	50% 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.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (in a facility) *Coverage for Skilled Nursing, Outpatient Rehabilitation and Inpatient Rehabilitation facility settings is limited to 150 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	50% coinsurance after deductible is met
Hospice	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Durable Medical Equipment	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs needed after cancer treatment is limited to 1 item per benefit period. Limit is combined In-Network and Non-Network. Coverage for hearing aids services is limited to 1 item per ear every 36 months. Covered for children 18 years of age or under. Limit is combined In-Network and Non-Network.*	50% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Core Plan

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Combined with medical deductible	Combined with medical deductible
Pharmacy Out of Pocket	Combined with medical out of pocket maximum	Combined with medical out of pocket maximum
Prescription Drug Coverage *Essential 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% coinsurance after deductible is met (retail and home delivery)	50% coinsurance after deductible is met (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.*	20% coinsurance after deductible is met (retail and home delivery)	50% coinsurance after deductible is met (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.*	20% coinsurance after deductible is met (retail and home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
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.*	20% coinsurance after deductible is met (retail and home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)

Your summary of benefits

Core Plan

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.
- 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).
- If office visit is a coinsurance, the coinsurance also applies to allergy injections.
- Certain diabetic supplies are covered subject to applicable prescription drug copayments/coinsurance 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 supplies not covered except diabetic test strips.
- DME 50% coinsurance for Network/Non-network Durable Medical Equipment, Medical Supplies, Prosthetics, and Orthotics. Excludes Diabetic Supplies and Mastectomy Prostheses which will apply the plan's cost shares.
- 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.
- The Rx option includes the Essential formulary which is a closed drug list with a focus on therapeutic efficacy and cost effectiveness.
- 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.
- Benefits are limited to abortions performed to preserve the life of the female upon whom the abortion is performed. Elective abortions are not a Covered Service.

- If you get Covered Services from a Physical Therapist or Occupational Therapist, you will not have to pay an office visit or outpatient Facility Copayment or Coinsurance that is higher than what you would pay for a Primary Care Physician office visit.

Your summary of benefits

Anthem

Buy Up Plan

Anthem® BlueCross and BlueShield

Your Plan: Anthem Blue Access PPO Option 29 with Rx Option E2

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.*	$2,500 person / $5,000 family	$7,500 person / $15,000 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.*	$6,600 person / $13,200 family	$19,800 person / $39,600 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	50% 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 $10 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	50% coinsurance after deductible is met

Your summary of benefits

Buy Up Plan

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Specialist Care Visit *When Allergy injections are billed separately by network providers, the member is responsible for a $10 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$50 copay per visit deductible does not apply	50% 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	50% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	$25 copay per visit deductible does not apply	50% coinsurance after deductible is met
On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	$25 copay per visit deductible does not apply	50% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 12 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	50% coinsurance after deductible is met
Other Services in an Office:		
Allergy Testing	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Chemo/Radiation Therapy Performed by a Primary Care Physician	$25 copay per visit deductible does not apply	50% coinsurance after deductible is met
Chemo/Radiation Therapy Performed by a Specialist	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Dialysis/Hemodialysis	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Prescription Drugs *For the drugs itself dispensed in the office through infusion/injection.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Buy Up Plan

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Diagnostic Services		
Lab:		
Office	No charge	50% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
X-Ray:		
Office	No charge	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Buy Up Plan

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency and Urgent Care		
Urgent Care (Office Setting) *When Allergy injections are billed separately by network providers, the member is responsible for a $10 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$75 copay per visit deductible does not apply	50% coinsurance after deductible is met
Urgent care(Facility Setting)		
Urgent Care: Facility fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Urgent Care: Doctor and other services	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$250 copay per visit and 20% coinsurance deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance deductible does not apply	Covered as In-Network
Ambulance (Air, Ground, and Water) *Non-emergency non-network Ambulance Services are limited to $50,000 per occurrence.*	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	50% coinsurance after deductible is met
Facility visit:		
Facility Fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Buy Up Plan

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Surgery		
Facility Fees:		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	50% 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 Skilled Nursing, Inpatient Physical Medicine and Rehabilitation including day rehabilitation is limited to 150 days combined per benefit period. Limit is combined In-Network and Non-Network.*	20% coinsurance after deductible is met	50% 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 charge	50% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Buy Up Plan

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 100 visits per benefit period. Limit is combined In-Network and Non-Network. Limits are combined for home health care and private duty nursing.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 20 visits per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 20 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	50% coinsurance after deductible is met
Outpatient Hospital *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 20 visits per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 20 visits per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
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.*	$50 copay per visit deductible does not apply	50% 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.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Pulmonary rehabilitation		

Your summary of benefits

Buy Up Plan

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
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.*	$50 copay per visit deductible does not apply	50% 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.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (in a facility) *Coverage for Skilled Nursing, Outpatient Rehabilitation and Inpatient Rehabilitation facility settings is limited to 150 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	50% coinsurance after deductible is met
Hospice	No charge	No charge
Durable Medical Equipment	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs needed after cancer treatment is limited to 1 item per benefit period. Limit is combined In-Network and Non-Network. Coverage for hearing aids services is limited to 1 item per ear every 36 months. Covered for children 18 years of age or under. Limit is combined In-Network and Non-Network.*	50% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Buy Up Plan

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 *Essential 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.*	$10 copay per prescription, deductible does not apply (retail) and $25 copay per prescription, deductible does not apply (home delivery)	50% coinsurance, 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.*	$35 copay per prescription, deductible does not apply (retail) and $105 copay per prescription, deductible does not apply (home delivery)	50% coinsurance, 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.*	$75 copay per prescription, deductible does not apply (retail) and $225 copay per prescription, deductible does not	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Your summary of benefits

Buy Up Plan

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
	apply (home delivery)	
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.*	25% coinsurance up to $350 per prescription, deductible does not apply (retail and home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Your summary of benefits

Buy Up Plan

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.
- 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 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 supplies not covered except diabetic test strips.
- DME 50% coinsurance for Network/Non-network Durable Medical Equipment, Medical Supplies, Prosthetics, and Orthotics. Excludes Diabetic Supplies and Mastectomy Prostheses which will apply the plan's cost shares.
- 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.
- The Rx option includes the Essential formulary which is a closed drug list with a focus on therapeutic efficacy and cost effectiveness.
- 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.
- Benefits are limited to abortions performed to preserve the life of the female upon whom the abortion is performed. Elective abortions are not a Covered Service.
- 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.

- If you get Covered Services from a Physical Therapist or Occupational Therapist, you will not have to pay an office visit or outpatient Facility Copayment or Coinsurance that is higher than what you would pay for a Primary Care Physician office visit.

Your summary of benefits

Anthem

Alternate Plan

Anthem® BlueCross and BlueShield

Your Plan: Anthem Blue Access PPO Option 22 with Rx Option E2

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.*	$1,500 person / $3,000 family	$4,500 person / $9,000 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.*	$6,500 person / $13,000 family	$19,500 person / $39,000 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	50% 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 $10 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	50% coinsurance after deductible is met

Your summary of benefits

Alternate Plan

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Specialist Care Visit *When Allergy injections are billed separately by network providers, the member is responsible for a $10 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$50 copay per visit deductible does not apply	50% 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	50% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	$25 copay per visit deductible does not apply	50% coinsurance after deductible is met
On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	$25 copay per visit deductible does not apply	50% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 12 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	50% coinsurance after deductible is met
Other Services in an Office:		
Allergy Testing	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Chemo/Radiation Therapy Performed by a Primary Care Physician	$25 copay per visit deductible does not apply	50% coinsurance after deductible is met
Chemo/Radiation Therapy Performed by a Specialist	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Dialysis/Hemodialysis	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Prescription Drugs *For the drugs itself dispensed in the office through infusion/injection.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Alternate Plan

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Diagnostic Services		
Lab:		
Office	No charge	50% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
X-Ray:		
Office	No charge	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Alternate Plan

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency and Urgent Care		
Urgent Care (Office Setting) *When Allergy injections are billed separately by network providers, the member is responsible for a $10 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$75 copay per visit deductible does not apply	50% coinsurance after deductible is met
Urgent care(Facility Setting)		
Urgent Care: Facility fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Urgent Care: Doctor and other services	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$250 copay per visit and 20% coinsurance deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance deductible does not apply	Covered as In-Network
Ambulance (Air, Ground, and Water) *Non-emergency non-network Ambulance Services are limited to $50,000 per occurrence.*	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	50% coinsurance after deductible is met
Facility visit:		
Facility Fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Alternate Plan

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Surgery		
Facility Fees:		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	50% 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 Skilled Nursing, Inpatient Physical Medicine and Rehabilitation including day rehabilitation is limited to 150 days combined per benefit period. Limit is combined In-Network and Non-Network.*	20% coinsurance after deductible is met	50% 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 charge	50% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Alternate Plan

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 100 visits per benefit period. Limit is combined In-Network and Non-Network. Limits are combined for home health care and private duty nursing.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 20 visits per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 20 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	50% coinsurance after deductible is met
Outpatient Hospital *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 20 visits per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities. Coverage for rehabilitative and habilitative speech therapy is limited to 20 visits per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
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.*	$50 copay per visit deductible does not apply	50% 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.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Pulmonary rehabilitation		

Your summary of benefits

Alternate Plan

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
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.*	$50 copay per visit deductible does not apply	50% 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.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (in a facility) *Coverage for Skilled Nursing, Outpatient Rehabilitation and Inpatient Rehabilitation facility settings is limited to 150 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	50% coinsurance after deductible is met
Hospice	No charge	No charge
Durable Medical Equipment	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs needed after cancer treatment is limited to 1 item per benefit period. Limit is combined In-Network and Non-Network. Coverage for hearing aids services is limited to 1 item per ear every 36 months. Covered for children 18 years of age or under. Limit is combined In-Network and Non-Network.*	50% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Alternate Plan

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 *Essential 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.*	$10 copay per prescription, deductible does not apply (retail) and $25 copay per prescription, deductible does not apply (home delivery)	50% coinsurance, 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.*	$35 copay per prescription, deductible does not apply (retail) and $105 copay per prescription, deductible does not apply (home delivery)	50% coinsurance, 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.*	$75 copay per prescription, deductible does not apply (retail) and $225 copay per prescription, deductible does not	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
	apply (home delivery)	
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.*	25% coinsurance up to $350 per prescription, deductible does not apply (retail and home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Your summary of benefits

Alternate Plan

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.
- 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 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 supplies not covered except diabetic test strips.
- DME 50% coinsurance for Network/Non-network Durable Medical Equipment, Medical Supplies, Prosthetics, and Orthotics. Excludes Diabetic Supplies and Mastectomy Prostheses which will apply the plan's cost shares.
- 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.
- The Rx option includes the Essential formulary which is a closed drug list with a focus on therapeutic efficacy and cost effectiveness.
- 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.
- Benefits are limited to abortions performed to preserve the life of the female upon whom the abortion is performed. Elective abortions are not a Covered Service.
- 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.

- If you get Covered Services from a Physical Therapist or Occupational Therapist, you will not have to pay an office visit or outpatient Facility Copayment or Coinsurance that is higher than what you would pay for a Primary Care Physician office visit.

hy healthiestyou™
By Teladoc.

KACo Benefits Group

Welcome to healthcare at your service.

Connect with a doctor 24/7 right over the phone!

VISIT A DOCTOR

When you get sick, our network of licensed doctors are standing by 24/7 waiting to help you. They can diagnose, treat, and often prescribe for an array of medical issues.

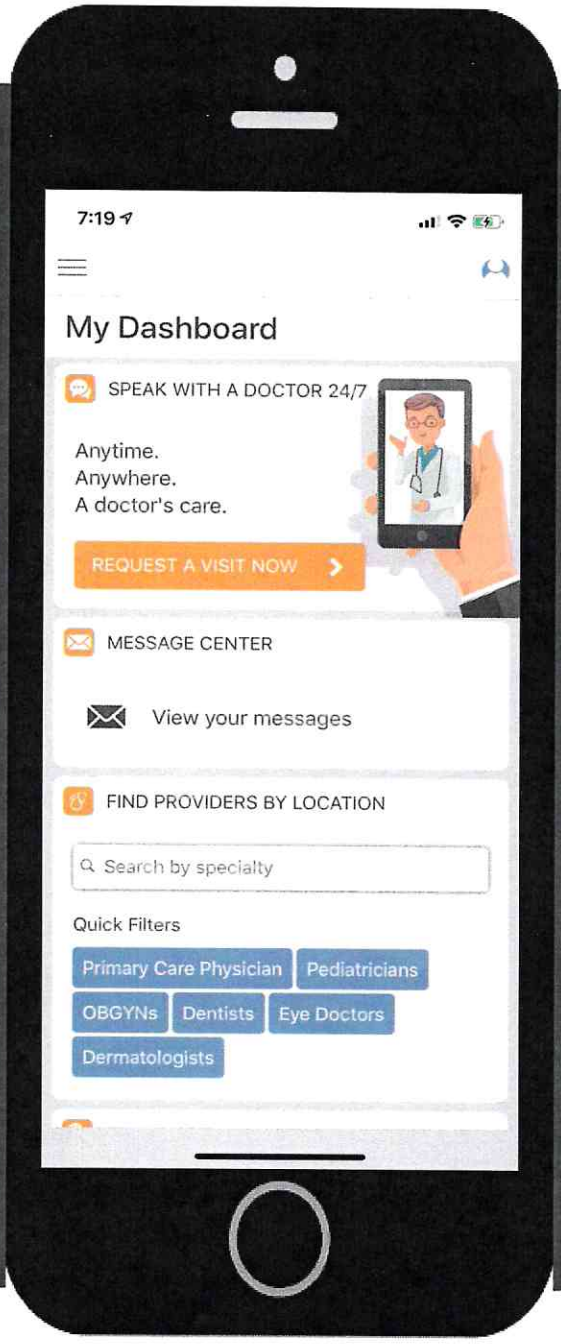
MESSAGE CENTER

Need access to previous visits or doctor's notes? Need to access an excuse note?

Our convenient Message Center provides quick access to previous visit information.

FAVORITES

Our intelligent bookmarking tool helps you store all of your favorite features, people, and places, from your PCP to your favorite recipe in one easy to access place!



FIND PROVIDERS & FIND FACILITIES

Need to search for a doctor, dentist, vet, or other provider? Our updated app has expanded searching for "Healthcare facilities" and has improved functionality for finding in-network providers near you.

PRICE PRESCRIPTION & PRICE PROCEDURE

Find "Cost-Saving Prescriptions" along with easy access to the "RX Discount Cards".

Our awesome price comparison engine gives you access to high, low, and average prices for medical procedures in your area.

INSURANCE SNAPSHOT

Connect medical insurance plans to locate in-network providers and track your deductibles to make sure you're minimizing out-of-pocket expenses.

Be sure to download the app today!

To talk to a doctor, simply launch the HY app and press the "Visit Doctor" button.

Don't have a smartphone? Simply call to visit a doctor.
866.703.1259

Healthiestyou only handles non-emergencies and is not intended to replace your primary care physician.

hy healthiestyou™
By Teladoc.

How to register and get started with HealthiestYou!

Step 1

Search and download "HealthiestYou" or "HY" in the app store or Google Play! Available on your iPhone or Android devices!

Step 2

Select "First time here? Register Now". Select employee as your membership type.

Step 3

Enter the Primary Member's Information:

- Last Name
- D.O.B.
- Zip Code

Step 4

A list of names associated with the account will appear. Select your name.

- Dependents under 18 will appear on the primary member's profile.
- Dependents over 18 will need to register their own account with a separate email.

Step 5

Enter in a valid email address and password.

Password must meet the listed requirements.

Step 6

Enter in the best number to reach you. Our doctors will use this number to contact you.

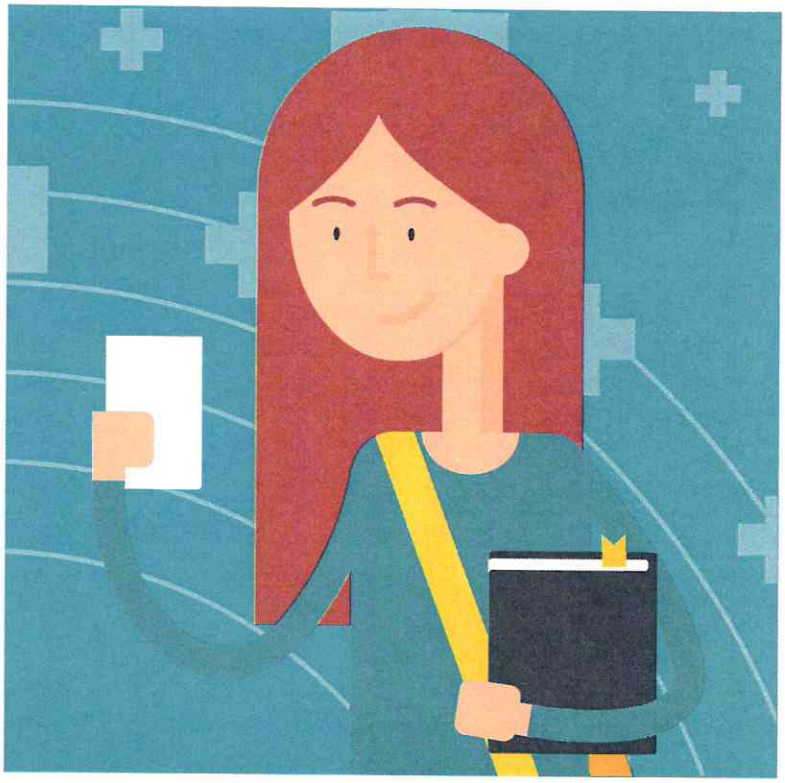
Select your preferred language.

Click "I Accept Terms & Conditions."

Click Finish.

hy healthiestyou™

KACo Benefits Group



Your healthcare just got a whole lot easier!

With HealthiestYou you can connect with a doctor who can diagnose, treat, and prescribe over the phone 24/7/365. Using HealthiestYou can SAVE YOU TONS OF MONEY and no more time wasted in waiting rooms or trying to schedule an appointment.

Our doctors are licensed and can handle an array of common ailments including allergies, earache, sore throat, pink eye, strep throat, urinary tract infection, and many more! HealthiestYou is great for families because your spouse and dependants can use it too and there is no limit on the number of times called or the duration of each call.

Talk to a doctor

Talk to a licensed, board-certified doctor to get a diagnosis and a treatment plan.

Get a prescription

If medically necessary, a prescription may be provided and electronically sent to a pharmacy of your choice.

Feel Better Soon

We hope you feel better quickly, but if not, call and talk to the doctor again. There is no limit to visits.

- 24x7 Unlimited doctor access
- Access by app or telephone
- Spouse and dependant use
- Find a nearby doctor, pharmacy, urgent care, ER, or even a vet
- Price and save on prescriptions
- Price procedures
- Search and compare doctors
- Sync & track deductibles
- Friendly reminders to save

DOWNLOAD THE APP!

Available on the iPhone App Store

ANDROID APP ON Google play

No Smartphone or Internet? No Problem! Simply call

866.703.1259

Blue View Vision℠

Option 28

Anthem BlueCross BlueShield

Vision Policy Included with Health Plan.

Welcome to your Blue View Vision plan!

You have many choices when it comes to using your benefits. As a Blue View Vision plan member, you have access to one of the nation's largest vision networks. You may choose from many private practice doctors, local optical stores, and national retail stores including LensCrafters®, Target Optical®, Sears Optical®, JCPenney® Optical and most Pearle Vision® locations. You may also use your in-network benefits to order eyewear online at Glasses.com and ContactsDirect.com. To locate a participating network eye care doctor or location, log in at **anthem.com**, or from the home page menu under Care, select **Find a Doctor**. You may also call member services for assistance at **1-866-723-0515**.

Out-of-Network – If you choose to, you may instead receive covered benefits outside of the Blue View Vision network. Just pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement up to your maximum out-of-network allowance.

YOUR BLUE VIEW VISION PLAN BENEFITS	IN-NETWORK	OUT-OF-NETWORK	FREQUENCY
Routine Eye Exam			
A comprehensive eye examination	$20 copay	Up to $42 allowance	Once every 12 months
Eyeglass Frames			
One pair of eyeglass frames	$130 allowance, then 20% off any remaining balance	Up to $45 allowance	Once every 24 months
Eyeglass Lenses *(instead of contact lenses)*			
One pair of standard plastic prescription lenses: • Single vision lenses • Bifocal lenses • Trifocal lenses	 $20 copay $20 copay $20 copay	 Up to $40 allowance Up to $60 allowance Up to $80 allowance	Once every 12 months
Eyeglass Lens Enhancements When obtaining covered eyewear from a Blue View Vision provider, you may choose to add any of the following lens enhancements at no extra cost.			
• Transitions Lenses (for a child under age 19) • Standard polycarbonate (for a child under age 19) • Factory scratch coating	$0 copay $0 copay $0 copay	No allowance when obtained out-of-network	Same as covered eyeglass lenses
Contact Lenses *(instead of eyeglass lenses)* Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.			
• Elective conventional (non-disposable) OR • Elective disposable OR • Non-elective (medically necessary)	$130 allowance, then 15% off any remaining balance $130 allowance *(no additional discount)* Covered in full	Up to $105 allowance Up to $105 allowance Up to $210 allowance	Once every 12 months

This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network. Benefits are payable only for expenses incurred while the group and insured person's coverage is in force. This information is intended to be a brief outline of coverage. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's policy, which shall control in the event of a conflict with this overview. This benefit overview is only one piece of your entire enrollment package.

EXCLUSIONS & LIMITATIONS (not a comprehensive list – please refer to the member Certificate of Coverage for a complete list)

Combined Offers. Not to be combined with any offer, coupon, or in-store advertisement.
Excess Amounts. Amounts in excess of covered vision expense.
Sunglasses. Plano sunglasses and accompanying frames.
Safety Glasses. Safety glasses and accompanying frames.
Not Specifically Listed. Services not specifically listed in this plan as covered services.
Lost or Broken Lenses or Frames. Any lost or broken lenses or frames are not eligible for replacement unless the insured person has reached his or her normal service interval as indicated in the plan design.
Non-Prescription Lenses. Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power.
Orthoptics. Orthoptics or vision training and any associated supplemental testing.

dental health OPTIONS® by Health Resources, Inc.

Product Summary Guide for Dental Health Options Plan 3

Dental Health Options by Health Resources Inc. offers convenient and affordable dental care that provides network savings and protection for your employees through our extensive dental network.

To find a dentist visit:
InsuringSmiles.com/FindADentist

PLAN ANNUAL MAXIMUM BENEFIT: $500 - $2,000

DENTAL SERVICES COVERED AT 100% *

PREVENTIVE SERVICES
Routine teeth cleaning
Fluoride applications
Sealants (permanent molar teeth only)
Space maintainers (not orthodontic retainers)

DIAGNOSTIC SERVICES
Evaluations (exams)
- Periodic, limited, comprehensive, periodontal

Radiographs (x-rays)
- Complete series
- Panoramic films
- Bitewings

Other procedures
- Pulp vitality tests
- Diagnostic casts

DENTAL SERVICES COVERED AT 80% *

RESTORATIVE
Silver fillings
- Primary teeth / Permanent teeth

White fillings
- Anterior teeth / Posterior teeth

ENDODONTICS
Root canal therapy
- Anteriors / Premolars / Molars
- Retreatment

ORAL SURGERY
Extractions
- Routine removals or exposed roots

DENTAL SERVICES COVERED AT 50% *

RESTORATIVE
Inlay/Onlay (metallic & porcelain)
Crowns
- Porcelain/ceramic
- Full cast/¾ cast
- Prefabricated stainless steel
- Recementation

Other restorative services
- Protective restoration
- Core buildup including pins
- Pin retention
- Post & core
- Labial veneers (anterior teeth)

ENDODONTICS
Vital pulpotomy (primary teeth only)
Pulp therapy (primary teeth only)
Apexification
Apicoectomy
Root amputation

PERIODONTICS
Gingivectomy, per quadrant
Crown lengthening
Osseous surgery
Soft tissue grafts
Distal or proximal wedge
Scaling and root planing
Full mouth debridement
Periodontal maintenance

PROSTHODONTICS
Removable
- Complete/Immediate dentures
- Partial dentures
  - All acrylic
  - Metal framework, acrylic saddles
- Repairs/Reline
- Tissue conditioning

Fixed bridgework
- Bridge pontics & retainers
- Resin bonded (Maryland) bridge
- Recementation
- Post & core

IMPLANT SUPPORTED PROSTHETICS (RESTORATIONS)
Removable dentures, abutment supported
Crowns, abutment supported
- Porcelain/ceramic/cast metal

Fixed bridgework, abutment supported
- Porcelain/ceramic/cast metal

ORAL SURGERY
Extractions
- Surgical removals
- Impactions

Natural tooth reimplantation
Surgical exposure or unerupted tooth
Biopsy, soft tissue
Incision and drainage of abscess
Frenectomy
Excise hyperplastic tissue
Alveoloplasty (smoothing of bone)

ADJUNCTIVE
Palliative emergency treatment
Anesthesia
- General anesthesia
- Intravenous sedation
- Analgesia (nitrous oxide)

Athletic mouth guards
Bleaching (anterior teeth, supervised in office)

LIFETIME ORTHODONTIC BENEFIT RIDER: $1,000 - $2,000

Adult & Dependent Children or Dependent Children Only

Procedures listed herein are payable at 50% up to the lifetime maximum benefit. To receive maximum benefit, the patient must be in active orthodontic treatment a minimum of two years while covered by the Plan. Once an individual has exhuasted her/her lifetime maximum benefit under any Plan, additional charges will be excluded.

Limited Orthodontic Treatment
Comprehensive Orthodontic Treatment
Interceptive Orthodontic Treatment
Treatment to Control Harmful Habits

Your Employer will sponsor your plan and select your individual annual maximum dollar level, of which the benefit accumulation period is the Plan year. Your employer will also collect your portion of the premiums via payroll deduction and define eligibility requirements. You may not add, drop or change coverage during each contract period unless a qualifying event occurs. All plans are issued subject to certain exclusions, limitations and restrictions such as frequency and age limitations. These exclusions, limitations and restrictions, and a listing of all covered services by ADA code, are described in the Employer group contract and your Member handbook, which are available on our website or by calling HRI at 800-727-1444.

* Applicable to covered services obtained from a network dentist. Non-participating dentists may balance bill.

OPTIONAL SAVINGS AVAILABLE FROM BLUE VIEW VISION IN-NETWORK PROVIDERS ONLY		In-network Member Cost (after any applicable copay)
Retinal Imaging - at member's option can be performed at time of eye exam		Not more than $39

Eyeglass lens upgrades
When obtaining eyewear from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lens copayment applies.
	∘ Transitions lenses (Adults)
	∘ Standard Polycarbonate (Adults)
	∘ Tint (Solid and Gradient)
	∘ UV Coating
	∘ Progressive Lenses[1]
	  ∘ Standard
	  ∘ Premium Tier 1
	  ∘ Premium Tier 2
	  ∘ Premium Tier 3
	∘ Anti-Reflective Coating[2]
	  ∘ Standard
	  ∘ Premium Tier 1
	  ∘ Premium Tier 2
	∘ Other Add-ons
		
		$75
		$40
		$15
		$15
		
		$65
		$85
		$95
		$110
		
		$45
		$57
		$68
		20% off retail price

Additional Pairs of Eyeglasses Anytime from any Blue View Vision network provider.	∘ Complete Pair ∘ Eyeglass materials purchased separately	40% off retail price 20% off retail price
Eyewear Accessories	∘ Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc.	20% off retail price
Contact lens fit and follow-up A contact lens fitting and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.	∘ Standard contact lens fitting[3] ∘ Premium contact lens fitting[4]	Up to $55 10% off retail price
Conventional Contact Lenses	∘ Discount applies to materials only	15% off retail price

[1] Please ask your provider for his/her recommendation as well as the available progressive brands by tier.

[2] Please ask your provider for his/her recommendation as well as the available coating brands by tier.

[3] Standard fitting includes spherical clear lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

[4] Premium fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

Discounts are subject to change without notice. Discounts are not 'covered benefits' under your vision plan and will not be listed in your certificate of coverage. Discounts will be offered from in-network providers except where state law prevents discounting of products and services that are not covered benefits under the plan. Discounts on frames will not apply if the manufacturer has imposed a no discount policy on sales at retail and independent provider locations. Some of our in-network providers include:

GLASSES.COM · contactsdirect · LensCrafters · Pearle Vision · Target Optical · Sears Optical · JCPenney optical

ADDITIONAL SAVINGS AVAILABLE THROUGH ANTHEM'S SPECIAL OFFERS PROGRAM *

Savings on items like additional eyewear after your benefits have been used, non-prescription sunglasses, hearing aids and even LASIK laser vision correction surgery are available through a variety of vendors. Just **log in at anthem.com**, select discounts, then Vision, Hearing & Dental.

* Discounts cannot be used in conjunction with your covered benefits.

OUT-OF-NETWORK

If you choose to receive covered services or purchase covered eyewear from an out-of-network provider, network discounts will not apply and you will be responsible for payment of services and/or eyewear materials at the time of service. Please complete an out-of-network claim form and submit it along with your itemized receipt to the fax number, email address, or mailing address below. To download a claim form, log in at **anthem.com**, or from the home page menu under Support select Forms, click Change State to choose your state, and then scroll down to Claims and select the Blue View Vision Out-of-Network Claim Form. You may instead call member services at **1-866-723-0515** to request a claim form.

To Fax: 866-293-7373
To Email: oonclaims@eyewearspecialoffers.com
To Mail: Blue View Vision
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

DAVIS VISION
EYECARE REFRAMED℠

Policy Available for Purchase

Ohio County Fiscal Court

Premier Voluntary Vision Plan

Healthy eyes and clear vision are an important part of your overall health and quality of life. Your vision plan helps you care for your eyes while saving you money by offering:

Paid-in-full eye examinations, eyeglasses and contacts!

Frame Collection: Your plan includes a selection of designer, name brand frames that are completely covered in full.[1]

Contact Lens Collection: Select from the most popular contact lenses on the market today with Davis Vision's Contact Lens Collection.[1]

One-year eyeglass breakage warranty included on plan eyewear at no additional cost!

How to locate a Network Provider...

Just log on to the Open Enrollment section of our Member site at davisvision.com and click "Find a Provider" to locate a provider near you including:

Visionworks

IN-NETWORK BENEFITS	
Eye Examination	Every 12 months, **Covered in full** after $10 copayment
Eyeglasses	
Spectacle Lenses	Every 12 months, **Covered in full** For standard single-vision, lined bifocal, or trifocal lenses after $25 copayment
Frames	Every 24 months, **Covered in full** Any Fashion, Designer or Premier frame from Davis Vision's Collection[1] (value up to $195) OR $150 retail allowance toward any frame from provider, plus 20% off balance[3] OR $200 allowance, plus 20% off balance[3] to go toward any frame from a Visionworks family of store locations.[5]
Contact Lenses	
Contact Lens Evaluation, Fitting & Follow Up Care	Every 12 months, Collection Contacts: **Covered in full** after $25 copay OR Non Collection Contacts: Standard Contacts: **Covered in full** after $25 copay Specialty Contacts: $60 allowance with 15% off balance[3] less $25 copay
Contact Lenses (in lieu of eyeglasses)	Every 12 months, **Covered in full** Any contact lenses from Davis Vision's Contact Lens Collection[1] OR $150 retail allowance toward provider supplied contact lenses, plus 15% off balance[3]

ADDITIONAL DISCOUNTED LENS OPTIONS & COATINGS		
MOST POPULAR OPTIONS Savings based on in-network usage and average retail values.	Without Davis Vision	With Davis Vision
Scratch-Resistant Coating	$25	$0
Polycarbonate Lenses	$66	$0[2]-$30
Standard Anti-Reflective (AR) Coating	$83	$35
Standard Progressives (no-line bifocal)	$198	$50
Photochromic Lenses (i.e. Transitions®, etc.)[4]	$110	$65

Lower costs and more benefits! *See the savings!*

Service	Without Davis Vision	With Davis Vision
Eye Examination	$103	$10
Lenses		
Bifocals	$116	$25
Scratch-Resistant Coating	$25	$0
Transitions®[5]	$110	$65
Frame	$160	$0
Total	$514	$100

Savings up to: **$414**

[1] The Davis Vision Collection is available at most participating independent provider locations.
[2] For dependent children, monocular patients and patients with prescriptions of 6.00 diopters or greater.
[3] Additional discounts not applicable at Walmart, Sam's Club or Costco locations..
[4] Transitions® is a registered trademark of Transitions Optical Inc.
[5] Enhanced frame allowance available at all Visionworks Locations nationwide.

Davis Vision has made every effort to correctly summarize your vision plan features. In the event of a conflict between this information and your organization's contract with Davis Vision, the terms of the contract or insurance policy will prevail.

OE01259 7/28/17

Davis Vision plans offer...

Value for our Members

A comprehensive benefit ensuring low out-of-pocket cost to members and their families. Our goal is 100% member satisfaction.

Convenient Network Locations

A national network of credentialed preferred providers throughout the 50 states.

Freedom of Choice

Access to care through either our network of independent, private practice doctors (optometrists and ophthalmologists) or select retail partners.

Value-Added Features:

- Mail Order Contact Lenses Replacement contacts (after initial benefit) through DavisVisionContacts.com mail-order service ensures easy, convenient, purchasing online and quick, direct shipping to your door. Log on to our member Web site for details.
- Laser Vision Correction discounts of up to 25% off the provider's Usual & Customary fees, or 5% off advertised specials, whichever is lower.
- Retinal Imaging available at a $39 Member Charge. Additional pairs of eyeglasses at 30% discount.[3]

Contact Info

For more details about the plan, just log on to the Open Enrollment section of our Member site at davisvision.com or call 1.877.923.2847 and enter Client Code 8129.

ADDITIONAL OPTIONS	WITHOUT DAVIS VISION	WITH DAVIS VISION
FRAMES		
Fashion Frame (from the Davis Vision Collection)	$100	$0
Designer Frame (from the Davis Vision Collection)	$160	$0
Premier Frame (from the Davis Vision Collection)	$195	$0
LENSES		
All Ranges of Prescriptions and Sizes	**$90**	**$0**
Plastic Lenses	**$78**	**$0**
Oversized Lenses	**$20**	**$0**
Tinting of Plastic Lenses	**$25**	**$0**
Scratch-Resistant Coating	**$25**	**$0**
Polycarbonate Lenses	$66	$0[1] or $30
Ultraviolet Coating	$25	$12
Standard Anti-Reflective (AR) Coating	$83	$35
Premium AR Coating	$104	$48
Ultra AR Coating	$121	$60
Standard Progressive Addition Lenses	$198	$50
Premium Progressives Addition Lenses	$247	$90
Ultra Progressives Addition Lenses	$369	$140
High-Index Lenses	$120	$55
Polarized Lenses	$103	$75
Photochromic Lenses (i.e. Transitions®, etc.)[2]	$110	$65
Scratch Protection Plan (Single vision | Multifocal lenses)		$20 | $40

[1] Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions 6.00 diopters or greater.

[2] Transitions® is a registered trademark of Transitions Optical, Inc.

[3] Some limitations apply to additional discounts, discounts not applicable at all in-network providers.

Out-of-Network Benefits

You may receive services from an out-of-network provider, although you will receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network. If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for reimbursement to:

Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

OUT-OF-NETWORK REIMBURSEMENT SCHEDULE
Eye Examination up to $40 | Frame up to $50 Spectacle Lenses (per pair) up to: Single Vision $40, Bifocal $60, Trifocal $80, Lenticular $100 Elective Contacts up to $105, Visually Required Contacts up to $225

Employee Assistance Program
KY Association of Counties (KACo)

Anthem. BlueCross BlueShield

The Anthem Employee Assistance Program (EAP) provides solutions to help you balance work and life through confidential and easily accessible services. Anthem EAP puts convenient resources within your reach, and that helps you – and your household members – stay healthy. Anthem EAP services include:

Face-to-Face Counseling. You and your household members are eligible for up to three visits for each personal situation, as needed. You don't have to have Anthem insurance to qualify for this benefit. You can simply call the toll-free Anthem EAP number or access services online using the "Member Center."

Legal Assistance. You can receive a free 30 minute consultation in person or over the phone at a time that is convenient for you. You can even receive a discount on fees should you retain the attorney. Online resources include free legal forms, seminars and a full library of articles.

Financial Assistance. Our financial professionals provide free telephonic consultation on the financial topics that are important to you. Counseling sessions have no time limitations, and are available without appointment during regular business. Online resources include an assortment of financial calculators and access to PocketSmith, a budgeting and management tool.

ID Recovery. Specialists are available 24/7 to assess your risk level and then identify steps to resolve potential identity theft. All services are provided to you free of charge. This may include completing any necessary paperwork, reporting to the consumer credit agencies, and negotiating with creditors to repair debt history. Our specialists will work with you to restore your financial identity to its pre-theft status. Free credit monitoring services available via the website.

Tobacco Cessation (Online and Coaching)

Online Program: LivingFree™ is a free 10 sessions, online training program which will help you learn how to break the tobacco habit. The program focuses on the root emotional and physical causes of using tobacco.

Telephonic Coaching: A free service provided via telephone or through instant messaging. The certified Coach will help you address the triggers of your tobacco use and how to overcome them as well as address issues related to weight management and fitness.

Dependent Care and Daily Living Resources. You and your household members can get information on child care, adoption, summer camps, college placement relocation, plus resources on elder care issues and assisted living by accessing the website at www.anthemeap.com

Other Web Resources. Full library of health and emotional well-being articles. Monthly webinars. Self-assessment tools on topics such as depression, relationships, anxiety, anger, alcohol, eating and more.

Crisis Consultation. If you have an emergency, simply call the Anthem toll-free number. Consultants are available 24/7/365 to help or just listen, depending on your needs.

To contact Anthem EAP, please call us toll-free at (800) 865-1044 or visit us at www.anthemeap.com Enter your company code: KACo

How to reach us

Help that goes where you do. Take us along. Here is a way to keep us handy.

Employee Assistance Program

800-865-1044
anthemeap.com
Enter **KACo** to log in.

Free, confidential help
24 hours a day,
7 days a week

Anthem. BlueCross BlueShield

Anthem. BlueCross BlueShield

Employee Assistance Program

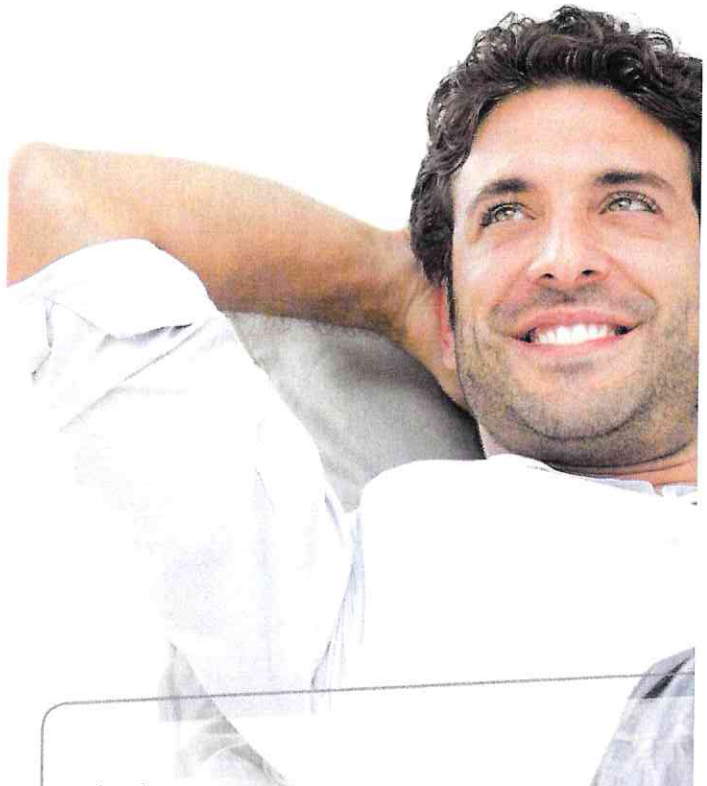
800-865-1044
anthemeap.com
Enter **KACo** to log in.

Anthem. BlueCross BlueShield

55635ANMENABS VPOD 08/15

Life just got easier

If it's on your mind, there's a good chance we can help

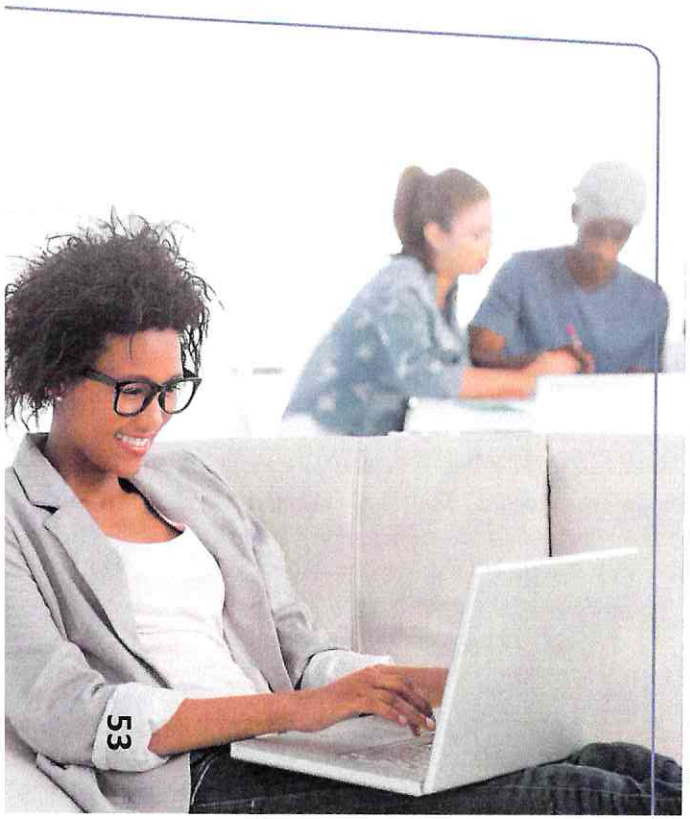


What is your Employee Assistance Program? We're the folks you can turn to when you need help meeting the everyday challenges of life. Call 800-865-1044, or visit anthemeap.com and enter KACo to log in. These services are available to you and your household members at no cost.

Anthem. BlueCross BlueShield

Lean on us – 24/7. We're here to help you with everyday problems and questions, big or small. No need to fill out paperwork or make an appointment to speak with your Employee Assistance Program (EAP) staff member. Just call 800-865-1044 or visit anthemeap.com. You'll be connected in an instant. We're here every day to help connect you to the support and referral services you need — day or night at no cost.

Put your mind at ease. Need some help getting your hands on legal forms like wills, or tips on buying or selling a home? Looking for information on emotional well-being? New to town and looking for a daycare center? Need pet care? Help for these and many more of life's demands can be found at anthemeap.com.



It is easy to reach us. Sometimes it's better to meet face to face with a professional. That's where your EAP counseling comes in. You have up to 3 free counseling visits per issue. Call the toll-free number and a representative will help you get started with complete confidentiality.*

Maybe you just need to ask a quick question about something. Call us. And, if you or a member of your household is in crisis, don't wait; call. We can help with that, too.

Get to know your EAP better at anthemeap.com

You'll find articles, checklists, quizzes and other helpful tools online. You can browse resources, attend a webinar or take an online class — right at your own computer. Here are some topics covered:

- Meeting the needs of work and family
- Finding child and elder care
- Giving and receiving feedback
- Handling grief and loss
- Parenting a child with special needs
- Living within a realistic budget
- Addressing addiction and recovery
- Dealing with identity theft
- Managing stress

Your privacy matters. Remember, EAP is here for you 24/7, so you can call from wherever or whenever it is convenient for you. Your privacy is important to us. No one will know you've called EAP unless you give permission in writing.* When you need answers, let EAP give you a helping hand. Just call 800-865-1044 or go to anthemeap.com and enter KACo.

*In accordance with federal and state law, and professional ethical standards.

This document is for general informational purposes. Check with your employer for specific information about benefits, limitations and exclusions.

Anthem. BlueCross BlueShield

Employee Navigator

Connecting employees with their benefits

Do you ever forget what your benefits cover?
Do you need a phone number or website for a carrier?
Do you need information about how to file a claim?

Get answers to these questions and more at Employee Navigator. This is a web portal designed to link you with your benefits, providing 24/7 access to your employee benefits information.

Keeping you connected with your benefits is our goal

To log into *Employee Navigator*, go to www.EmployeeNavigator.com and use the login information below:

User Name: Ohio County Fiscal Password: Court

(Please note that User Name and Password are case sensitive)

The following required notifications may be accessed at Employee Navigator:

- Summaries of Benefits and Coverage
- Important Notices Regarding Employee Benefits
- Premium Assistance under Medicaid & Children's Health Insurance Program (CHIP)

If you would like a printed copy of these notices, please notify Anne Melton at 270-298-4402 or Peel and Holland at 270-253-3294.

Peel & Holland

Insurance ▪ Risk Consulting ▪ Employee Benefits

If you are interested in AFLAC coverage call:

William Jones, Aflac Agent
958 Collett Avenue Suite 200
Bowling Green KY 42101
Phone 270 320 1911
Fax 866 369 1999
Email: w5_jones@us.aflac.com

This coverage would include:

Accident
Cancer
Disability
Critical Illness

Can you and your family afford to be without Aflac?

Why Aflac?

Aflac is different from health insurance; it's insurance for daily living.

Aflac pays cash benefits directly to you to help with daily expenses when you're sick or hurt. You can use your Aflac benefit check to help pay for many out-of-pocket medical expenses (co-pays, deductibles, etc.) you incur when you are sick or hurt or help pay for groceries, child care, rent…it's totally up to you. Major medical pays for doctors and hospitals.

Policies to choose from; see brochures for more!

Policy	Need	Highlights	Rates per Week
Accident	Our most popular policy. Helps provide a financial cushion so it won't hurt when you get hurt. Accident coverage for the entire family.	• $120-$170 for initial emergency visit • $1500 initial hospitalization, $300/day ongoing, up to 365 days. • Surgery, Physical Therapy, Chiropractic • $50,000 for Accidental Death • $60 wellness per year	Individual--- **$7.74** Employee & Spouse--- **$10.30** One Parent Family--- **$11.99** Two Parent Family--- **$15.11**

Cancer	1 in 2 males and 1 in 3 females will be diagnosed with Cancer in their lifetime. Cancer is the #1 cause of medical bankruptcy in the US. This is a stream of finances to help at a critical time.	• $4,000 First Occurrence.
		• Additional benefits for:
		  • Radiation
		  • Chemotherapy
		  • Hospitalization
		  • Surgery
		  • Travel and Lodging
		Children Covered at **NO** Additional Cost
			Individual--- **$8.38**
			Employee & Spouse--- **$14.41**
			One Parent Family--- **$8.38**
			Two Parent Family--- **$14.41**

Disability	Disability benefits provide a source of income when you are hurt or sick and can't work. If you are unable to work due to sickness or accident how will you pay your bills without a paycheck?	• Guaranteed issue • Benefits up to $5,000 per month. • Benefit period up to 24 months. • 0/7 day elimination period	*Please see Aflac Representative for quotes. Quotes based on income.*
Critical Illness	About every 34 seconds someone suffers a heart attack and about every 40 seconds someone suffers a stroke.	• Lump sum benefit paid directly to employee • Dependent children are covered at no additional cost • Guaranteed issue coverage amount • Subsequent critical illness event benefit if you have a recurrence or another critical illness later in life	*Please see Aflac Representative for quotes. Quotes based on benefit amount, age, and smoker/nonsmoker.*

This is for demonstration purposes and details may change. Please refer to product brochures and our Aflac Agent for product details and information on Life Insurance.

We've got you under our wing!

Aflac®