HEALTH FUND (HRA) OPTIONS FOR 2016-2017
PATTONVILLE SCHOOL DISTRICT

Health Reimbursement Arrangement:
Your District has established a health fund that may be used to cover many medical expenses throughout the year. You will continue to have copays for your prescriptions. Amounts paid by the fund for services covered by the health plan are applied toward your deductible. Please refer to your benefit summary for further information.

Member Responsibility:
Once you've used the dollars in your health fund, you will be responsible for the (Corridor = Deductible – Fund)

Your health fund options are outlined below:

Premium Plan In Network

Individual		**Family**	
Fund Amount	**Corridor**	**Fund Amount**	**Corridor**
$2,500	$500	$5,000	$1,000
$2,000	$1,000	$4,000	$2,000
$1,000	$2,000	$2,000	$4,000

Please refer to the Summary of Benefits for detailed information on your coverage and out-of-pocket costs.

Your Guide to Making Payments at the Point of Care

When you receive services at your health care professional's facility, the exact amount that you owe is not determined until your claim is processed by Anthem Blue Cross Blue Shield.

We have prepared this guide so you know how claims are processed and what you may need to do.

How payment usually works

In most cases, the health care facility will not ask you to make a payment at the time of your visit, with the exception of a copay, if your plan has a copay. After you have received care, your health care professional will send the claim directly to Anthem. Anthem follows two steps:

First, Anthem determines if the care is covered by your CSD Insurance Trust Medical Plan. Anthem verifies whether or not you are enrolled in the District's Healthcare Reimbursement Arrangement (HRA) Plan. If you are in an HRA Plan, Anthem automatically reimburses the health care provider from the available funds in your HRA for the amount you owe.

Next, Anthem sends one Explanation of Benefits (EOB) stating what part of the covered services the CSD Plan paid and also showing the amount reimbursed out of your HRA Plan.

Your health care provider will bill you the remaining balance due.

If you are asked to make a payment

If your health care provider asks you for a payment before your claim is processed by Anthem, here are some questions you should ask:

- Has he or she considered how much Anthem will pay for the service?
- Has he or she checked your current deductible status and verified coverage for service?
- Does he or she know about automatic claim forwarding, and that Anthem will make an automatic payment on your behalf using money from your Healthcare Reimbursement Arrangement account?
- Has he or she checked if there is money in your HRA account that would cover your deductible?
- Can he or she contact Anthem's Medical/HRA Customer Service to verify that there is money available in your account? (Phone 855-272-4938.)

Tips for making payments

- Make certain that the provider claims and HRA reimbursements have been processed by Anthem before you pay a bill from a health care provider. (Refer to your Explanation of Benefits/HRA Statement.)
- Log into www.Anthem.com or call Anthem Customer Service at 855-272-4938 to see how much you have paid toward your deductible, check any pending claims, and check the balance of your HRA Plan, so you can discuss with your health care provider.
- If you make a payment at the time of service and later notice that a duplicate payment was made, contact your health care provider directly. Before calling, be certain to have a copy of your Explanation of Benefits/HRA Statement plus your check number or credit/debit card statement that shows your payment. If you need additional assistance after talking with your health care provider, please use the contact information below.

Your Summary of Benefits

Pattonville School District – Premium Plan
Blue Access Choice ® PPO
Effective 10/1/2016

Covered Benefits	Network	Non-Network *For all non-network services, reimbursement is based on allowable amount. Member is responsible for the difference between the amount charged and the allowable amount, in addition to deductible and coinsurance*
Deductible (Single/Family) network and non network deductibles commingled network $ contribute to non network and non network $ contribute to network	$3,000 / $6,000	$3,500/$7,000
Out-of-Pocket Limit (Single/Family) network and non network oop commingled network $ contribute to non network and non network $ contribute to network	$3,000/$6,000	$6,500/$13,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/ Specialty Care Physician (SCP) Including allergy serum:	$25/$35	20%after deductible
• allergy injections (PCP and SCP)	No copayment/coinsurance	20% after deductible
• office surgeries	No copayment/coinsurance	20% after deductible
• allergy testing	No copayment/coinsurance	20% after deductible
• MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, and pharmaceutical products	No copayment/coinsurance	20% after deductible
Preventive Care Services Services include but are not limited to: Routine Exams, Pelvic Exams, Pap testing, PSA tests, Immunizations[1], Mammograms, and Hearing screenings		
• Physician Home and Office Visits (PCP/SCP)	No copayment/coinsurance	20% after deductible
• Other Outpatient Services @ Hospital/Alternative Care Facility	No copayment/coinsurance	20% after deductible
• Immunizations through age 5	No copayment/coinsurance	No copayment/coinsurance
• Routine vision, annual diabetic eye exam	$25	No copayment/coinsurance **Reimbursement is based on allowable amount. Member is responsible for the difference between the amount charged and the allowable amount, in addition to deductible and coinsurance

Your Summary of Benefits

Covered Benefits	Network	Non-Network *For all non-network services, reimbursement is based on allowable amount. Member is responsible for the difference between the amount charged and the allowable amount, in addition to deductible and coinsurance*
Emergency and Urgent Care Emergency Room Services • facility/other covered services (copayment waived if admitted) Urgent Care Center Services MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, and pharmaceutical products • Allergy injections • Allergy testing	 $200 $50	 $200 No copayment/coinsurance **Reimbursement is based on allowable amount. Member is responsible for the difference between the amount charged and the allowable amount, in addition to deductible and coinsurance
Inpatient and Outpatient Professional Services Include but are not limited to: • Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams	0% after deductible	20% after deductible
Blue 4.0		
Inpatient Facility Services Unlimited days except for: • 60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) • 90 days Network/Non-Network combined for skilled nursing facility	0% after deductible	20% after deductible
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	0% after deductible	20% after deductible

Your Summary of Benefits

Covered Benefits	Network	Non-Network *For all non-network services, reimbursement is based on allowable amount. Member is responsible for the difference between the amount charged and the allowable amount, in addition to deductible and coinsurance*
Other Outpatient Services (network & non network combined)(including but not limited to): • Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds, and other diagnostic outpatient services. • Home Care Services Unlimited(excludes IV Therapy) • Durable Medical Equipment and Orthotics (excluding Prosthetic Devices, Limbs and Medical Supplies) • Prosthetic Devices • Prosthetic Limbs • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	0% after deductible 0% after deductible 0% after deductible	20% after deductible 20% after deductible 0% after deductible
Outpatient Therapy Services (Combined Network & Non-Network limits apply) • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility • NOTE: PT OT ST Pulmonary and Cardiac pay at $25 copay ; Chiro pays at $35 copay Limits apply to: • Physical/Manipulation therapy excluding Chiropractic Services: 60 visits • Occupational therapy: 60 visits • Chiropractic Services: 26 visits • Speech therapy: 60 visits • Cardiac Rehabilitation: 60 visits • Pulmonary Rehabilitation: 60 visits	 $25/$35 $25/$35	 20% after deductible 20% after deductible
Accidental Dental Services - unlimited (Network and Non-network combined)	Copayments/Coinsurance based on setting where covered services are received	20% after deductible

Your Summary of Benefits

Covered Benefits	Network	Non-Network *For all non-network services, reimbursement is based on allowable amount. Member is responsible for the difference between the amount charged and the allowable amount, in addition to deductible and coinsurance*
Behavioral Health Services[2]: Mental Health and Substance Abuse (Network and Non-Network) • Inpatient Facility Services • Inpatient Professional Services • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services, Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional	0% after deductible 0% after deductible $25/$25 0% after deductible	20% after deductible
Human Organ and Tissue Transplants[3] using Anthem Centers for Transplant Excellence • Acquisition and transplant procedures, harvest and storage.	No copayment/coinsurance	30% after deductible
Prescription Drugs Network Tier structure equals 1/2/3 • Network Retail Pharmacies: (30-day supply) Includes diabetic test strip Anthem Rx Direct Mail Service: (90-day supply) Includes diabetic test strip Member may be responsible for additional cost when not selecting the available generic drug. Medicare Rx - Wrap Specialty medications are limited to 30 day supply regardless of whether they are retail or mail order.	$5/$30/$55 $10/$60/$110 Out of Pocket Limit None	50% Not covered
Lifetime Maximum	Unlimited	Unlimited

Notes:

- Flat dollar copayments and Non Network Human Organ and Tissue Transplants are excluded from the out-of-pocket limits. Also Prescription Drug deductibles/copayments/coinsurance are excluded from the out-of-pocket limits.
- Deductible(s) apply only to covered medical services listed with a percentage (%) coinsurance.
- Dependent age: to end of the month which the child attains age 26
- Specialist copayment is applicable to all Specialists excluding General Physicians, Internist, Pediatricians, OB/GYNs and Geriatrics or any other Network Provider as allowed by the plan.
- When allergy injections are rendered with a Physicians Home and Office Visit, only the Office Visit cost share applies.
- No copayment/coinsurance means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan.
- SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
- Certain diabetic and asthmatic supplies have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies, except diabetic test strips. This includes Blood Sugar Diagnostics (blood test strips), Glucometers, Insulin Syringes, Lancets, and Urine Test Strips.

Your Summary of Benefits

- Benefit period = plan year
- Elective abortions are not covered.
- Mammograms (Routine and Diagnostic) , are no copayment/coinsurance in Network office and outpatient facility settings.
- 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.
- Infertility not covered; TMJ not covered

1. These covered services for age 6 and above are not subject to the deductible/copayment if you have a flat dollar copayment and if rendered without an office visit
2. We encourage you to review the Schedule of Benefits for limitations. .
3. Kidney and cornea are treated the same as any other illness and subject to the medical benefits.
4. Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.

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

Grandfathered Health Plan
Anthem Blue Cross and Blue Shield believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections of the Affordable Care Act apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Anthem Blue Cross and Blue Shield at the telephone number printed on the back of your member identification card, or contact your group benefits adminstrator if you do not have an identifiication card. For ERISA plans, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or *www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For nonfederal governmental plans, you may also contact the U.S. Department of Health and Human Services at www.healthcare.gov*.

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.

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

Your Summary of Benefits

Pattonville School District - Kidz Plan
Blue Access Choice PPO
Effective 10/1/2016

Covered Benefits	Network	Non-Network *For all non-network services, reimbursement is based on allowable amount. Member is responsible for the difference between the amount charged and the allowable amount, in addition to deductible and coinsurance*
Deductible (Single/Family) network and non network deductibles commingled network $ contribute to non network and non network $ contribute to network	$750/$2,250	$1,500/$4,500
Out-of-Pocket Limit (Single/Family) network and non network oop commingled network $ contribute to non network and non network $ contribute to network *Note:* All copays, including prescription drug copays, apply to out-of-pocket limit.	$3,500/$10,500	$6,500/$19,500
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/ Specialty Care Physician (SCP) Including Office Surgeries and allergy serum: • allergy injections (PCP and SCP) • allergy testing • MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, and pharmaceutical products	20% after deductible 20% after deductible 20% after deductible 20% after deductible	40% after deductible 40% after deductible 40% after deductible 40% after deductible
Preventive Care Services Services include but are not limited to: Routine Exams, Mammograms, Pelvic Exams, Pap testing, PSA tests, Immunizations[1], Annual diabetic eye exam, Routine Vision and Hearing screenings • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility Immunizations through age 5	 No copayment/coinsurance No copayment/coinsurance No copayment/coinsurance	 40% after deductible 40% after deductible No copayment/coinsurance Reimbursement is based on allowable amount. Member is responsible for the difference between the amount charged and the allowable amount, in addition to deductible and coinsurance

Your Summary of Benefits

Covered Benefits	Network	Non-Network *For all non-network services, reimbursement is based on allowable amount. Member is responsible for the difference between the amount charged and the allowable amount, in addition to deductible and coinsurance*
Emergency and Urgent Care		
Emergency Room Services	$150	$150
• facility/other covered services (copayment waived if admitted)		
Urgent Care Center Services	$75	40% after deductible
• MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, and pharmaceutical products		40% after deductible
• Allergy injections		40% after deductible
• Allergy testing		40% after deductible
Inpatient and Outpatient Professional Services Include but are not limited to: • Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams	20% after deductible	40% after deductible
Blue 5.0		
Inpatient Facility Services Unlimited days except for: • 60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) • 90 days Network/Non-Network combined for skilled nursing facility	20% after deductible	40% after deductible
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	20% after deductible	40% after deductible

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Covered Benefits	Network	Non-Network *For all non-network services, reimbursement is based on allowable amount. Member is responsible for the difference between the amount charged and the allowable amount, in addition to deductible and coinsurance*
Other Outpatient Services (network & non network combined)(including but not limited to): • Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds, and other diagnostic outpatient services. • Home Care Services unlimited (excludes IV Therapy) • Durable Medical Equipment and Orthotics (excluding Prosthetic Devices, Limbs and Medical Supplies) • Prosthetic Devices • Prosthetic Limbs • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	20% after deductible 20% after deductible 20% after deductible	40% after deductible 40% after deductible 20% after deductible
Outpatient Therapy Services (Combined Network & Non-Network limits apply) • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: • Physical/Manipulation therapy excluding Chiropractic Services: 60 visits • Occupational therapy: 60 visits • Chiropractic Services: 26 visits • Speech therapy: 60 visits • Cardiac Rehabilitation: 60 visits • Pulmonary Rehabilitation: 60 visits	20% after deductible 20% after deductible	40% after deductible 40% after deductible
Accidental Dental Services unlimited (Network and Non-network combined)	20% after deductible	40% after deductible
Behavioral Health Services[2]: Mental Health and Substance Abuse (Network and Non-Network) • Inpatient Facility Services • Inpatient Professional Services • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services, Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional	20% after deductible 20% after deductible 20% after deductible 20% after deductible	40% after deductible

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Human Organ and Tissue Transplants[3] using Anthem Centers for Transplant Excellence • Acquisition and transplant procedures, harvest and storage.	No copayment/coinsurance	30% after deductible
Prescription Drugs Network Tier structure equals 1/2/3 • Network Retail Pharmacies: (30-day supply) Includes diabetic test strip • Anthem Rx Direct Mail Service: (90-day supply) Includes diabetic test strip Member may be responsible for additional cost when not selecting the available generic drug. Medicare Rx - Wrap Specialty medications are limited to 30 day supply regardless of whether they are retail or mail order.	 $10/$25/$45 $25/$62/$112	 50% Not covered
Lifetime Maximum	Unlimited	Unlimited

Notes:

- Flat dollar copayments and Non Network Human Organ and Tissue Transplants are excluded from the out-of-pocket limits. Also Prescription Drug deductibles/copayments/coinsurance are excluded from the out-of-pocket limits.
- Deductible(s) apply only to covered medical services listed with a percentage (%) coinsurance.
- Dependent age: to end of the month which the child attains age 26
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- PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan.
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