Your Summary of Benefits

The CSD Insurance Trust - Kidz Plan
Blue Access Choice PPO
Effective 10/1/2018

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

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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	$150 Addtl $250 penalty for non-emergent use (applies to ages 15 & over) $75	$150 40% after deductible 40% after deductible 40% after deductible 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
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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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) (90-day supply available for 3x copay) 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
- 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.
- 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.
- 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.

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.