

Educational Purchasing Council – Covington Core Option Blue AccessSM (PPO) Summary of Benefits, Effective October 1, 2008

Covered Benefits	Network	Non-Network
Deductible (Single/Family) <i>(Applies only to percent (%) copayments)</i>	\$100/\$200	\$300/\$600
Out-of-Pocket Maximum (Single/Family)	\$1,000/\$2,000	\$2,000/\$4,000
Physician Office Services Including Office Surgeries, allergy serum and injections ¹ • Allergy testing	\$20 Additional 20%	30% 30%
Preventive Care Medical History Mammography ¹ , Pelvic Exams, Pap testing and PSA tests Immunizations ¹ Annual diabetic eye exam Annual Vision and Hearing exams	\$20	30%
Outpatient Physical Medicine Therapies (Combined Network & Non-Network limits apply) Physical/Occupational therapy: 30/30 visit limit Spinal manipulations: 12 visit limit Speech therapy: 20 visit limit	Copayments based on place of service	Copayments based on place of service
Inpatient Services Unlimited days except for: 60 days Network/Non-Network combined for physical medicine/rehab 180 days Network/Non-Network combined for skilled nursing facility	10%	30%
Outpatient Surgery Hospital/Alternative Care Facility	10%	30%
Other Outpatient Services Hospital/Alternative Care Facility	10%	30%
Inpatient and Outpatient Professional Charges	10%	30%
Home Care Services 30 visits non-network limit for Home Care, excludes IV therapy	10%	30%
Hospice Services	20%	20%
Emergency and Urgent Care: Emergency Care in Emergency Room <i>(covers all services, copayment waived if admitted, then inpatient copayment applies)</i> Urgent Care Facility	\$75 \$35	\$75 \$35
Ambulance Services	Covered in full	Covered in full
Maternity Services	10%	30%
Non-biologically Based Mental Illness and Substance Abuse² (limits and maximums apply) Inpatient: 30 Network days (includes inpatient mental health Non-Network) Outpatient: 50 Network visits 10 Non-Network mental health visits Inpatient and outpatient substance abuse \$550 Non-Network <i>(Substance abuse rehabilitation programs are limited to two per lifetime Network and Non-Network combined.)</i> <i>Call 1-800-788-4003 for authorized referral</i> Biologically Based Mental Illnesses paid same as any other illness.	10% Copayments based on place of service	30% Copayments based on place of service

Lifetime Maximum (Combined Network and Non-Network)	\$5 million	\$5 million
Human Organ and Tissue Transplants except Kidney and Cornea transplants ³ A separate \$1 million lifetime maximum applies (Combined Network and Non-Network)	Covered in full	50%
Medical Supplies, Equipment and Appliances	20%	40%
Prescription Drug Options**: Network Retail Pharmacies: (30-day supply) Includes diabetic test strip Anthem Rx Direct Mail Service: (60-day supply) Includes diabetic test strip Specialty Medications must be obtained via our Specialty Pharmacy network in order to receive network level benefits.	\$10 gen form/\$20 brand form \$30 non-form generic/brand \$10 gen form/\$20 brand form \$30 non-form generic/brand	50%, min \$30* Not covered

Notes:

- All deductibles and copayments apply toward the Out-of-Pocket Maximum (except prescription drug, human organ and tissue transplants, excluding kidney and cornea, and flat dollar copayments for Preventive Care, Physician Office Services and Urgent Care).
- Deductible(s) apply only to covered services listed with a percentage (%) copayment excluding prescription drugs and allergy testing (**Network**). Deductible(s) do apply to allergy testing on Saver Plans.
- Network and Non-network deductibles, copayments and out-of-pocket maximums are separate and do not accumulate toward each other.
- Dependent age: to the end of the calendar year in which the child attains age 19; or to the end of the calendar year in which the child attains age 24 if the child qualifies as a Federal tax exemption.

¹ These covered services are covered in full if you have a flat dollar copayment and if rendered without an office visit.

² Mental health/substance abuse must be authorized by the mental health administrator for services to be covered at the highest benefit level. Refer to Schedule of Benefits for limitations.

³ Kidney and Cornea are treated the same as any other illness and subject to the medical benefits and lifetime maximum.

*Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.

**If applicable, all prescription drug expenses (Network/Non-network, Retail/Mail-service combined) apply to the per individual deductible. Once the deductible is met, the appropriate copayment applies.

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 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.

***Educational Purchasing Council – Covington High Option
Blue AccessSM (PPO)
Summary of Benefits, Effective October 1, 2008***

Covered Benefits	Network	Non-Network
Deductible (Single/Family) <i>(Applies only to percent (%) copayments)</i>	\$100/\$200	\$300/\$600
Out-of-Pocket Maximum (Single/Family)	\$750/\$1,500	\$1,500/\$3,000
Physician Office Services Including Office Surgeries, allergy serum and injections ¹ • Allergy testing	\$15 Covered in full	20% 20%
Preventive Care Medical History Mammography ¹ , Pelvic Exams, Pap testing and PSA tests Immunizations ¹ Annual diabetic eye exam Annual Vision and Hearing exams	\$15	20%
Outpatient Physical Medicine Therapies (Combined Network & Non-Network limits apply) Physical/Occupational therapy: 30/30 visit limit Spinal manipulations: 12 visit limit Speech therapy: 20 visit limit	Copayments based on place of service	Copayments based on place of service
Inpatient Services Unlimited days except for: 60 days Network/Non-Network combined for physical medicine/rehab 180 days Network/Non-Network combined for skilled nursing facility	Covered in full	20%
Outpatient Surgery Hospital/Alternative Care Facility	Covered in full	20%
Other Outpatient Services Hospital/Alternative Care Facility	Covered in full	20%
Inpatient and Outpatient Professional Charges	Covered in full	20%
Home Care Services 30 visits non-network limit for Home Care, excludes IV therapy	Covered in full	20%
Hospice Services	Covered in full	Covered in full
Emergency and Urgent Care: Emergency Care in Emergency Room <i>(covers all services, copayment waived if admitted, then inpatient copayment applies)</i> Urgent Care Facility	\$75 \$35	\$75 \$35
Ambulance Services	Covered in full	Covered in full
Maternity Services	Covered in full	20%
Non-biologically Based Mental Illness and Substance Abuse ² (limits and maximums apply) Inpatient: 30 Network days (includes inpatient mental health Non-Network) Outpatient: 50 Network visits 10 Non-Network mental health visits Inpatient and outpatient substance abuse \$550 Non-Network <i>(Substance abuse rehabilitation programs are limited to two per lifetime Network and Non-Network combined.)</i> <i>Call 1-800-788-4003 for authorized referral</i> Biologically Based Mental Illnesses paid same as any other illness.	Covered in full Copayments based on place of service	20% Copayments based on place of service

Lifetime Maximum (Combined Network and Non-Network)	\$5 million	\$5 million
Human Organ and Tissue Transplants except Kidney and Cornea transplants ³ A separate \$1 million lifetime maximum applies (Combined Network and Non-Network)	Covered in full	50%
Medical Supplies, Equipment and Appliances	20%	40%
Prescription Drug Options**: Network Retail Pharmacies: (30-day supply) Includes diabetic test strip Anthem Rx Direct Mail Service: (60-day supply) Includes diabetic test strip Specialty Medications must be obtained via our Specialty Pharmacy network in order to receive network level benefits.	\$8 gen form/\$15 brand form \$25 non-form generic/brand \$8 gen form/\$15 brand form \$25 non-form generic/brand	50%, min \$30* Not covered

Notes:

- All deductibles and copayments apply toward the Out-of-Pocket Maximum (except prescription drug, human organ and tissue transplants, excluding kidney and cornea, and flat dollar copayments for Preventive Care, Physician Office Services and Urgent Care).
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Refer to Schedule of Benefits for limitations.

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