Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Plan: CEBCO Anthem Blue Access PPO **ASHLAND COUNTY PLAN YEAR 2024/ 2D-Wellness Plan**

Your Network: Blue Access

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$800 person / $1,600 family	$1,600 person / $3,200 family
Overall Out-of-Pocket Limit	$3,200 person / $6,400 family	$6,400 person / $12,800 family
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit. All medical deductibles, copayments and coinsurance apply toward the out-of-pocket limit(s) (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services). In-Network and Non-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Medical Chats and Virtual Visits for Primary Care *from our Online Provider K Health, available through Sydney Health are covered at $0 copay per visit medical deductible does not apply.*		
Virtual Visits from online provider LiveHealth Online *for urgent/acute medical and mental health and substance abuse care available through Sydney Health or via www.livehealthonline.com are covered at $0 copay per visit medical deductible does not apply.*		
Primary Care (PCP) and Mental Health and Substance Abuse Care *virtual and office*	$20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Specialist Care *virtual and office*	$40 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Manipulation Therapy *Coverage is limited to 12 visits per benefit period.*	$40 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Other Services in an Office		
Allergy Testing *When Allergy injections are billed separately by network providers, the member is responsible for a $5 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Prescription Drugs *Dispensed in the office*	25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Surgery	$40 copay per visit medical deductible does not apply‡	50% coinsurance after medical deductible is met
Preventive care / screenings / immunizations	No charge	50% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	50% coinsurance after medical deductible is met
Diagnostic Services **Lab**		
Office	No charge	50% coinsurance after medical deductible is met
Outpatient Hospital	25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
X-Ray		
Office	No charge	50% coinsurance after medical deductible is met
Outpatient Hospital	25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Hospital	25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	$50 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$250 copay per visit and 0% coinsurance medical deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	0% coinsurance medical deductible does not apply	Covered as In-Network
Ambulance	25% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse Care at a Facility		
Facility Fees	25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Doctor Services	25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Doctor and Other Services		
Hospital	25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Human Organ and Tissue Transplants *Cornea transplants are treated the same as any other illness and subject to the medical benefits.*	25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Physician and other services *including surgeon fees*	25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Home Health Care *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for occupational therapy is limited to 30 visits per benefit period, physical therapy is limited to 30 visits per benefit period and speech therapy is limited to 20 visits per benefit period.*		
Office	$40 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Outpatient Hospital	25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Pulmonary rehabilitation *Coverage is limited to 20 visits per benefit period.*		
Office	$40 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Outpatient Hospital	25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Cardiac rehabilitation *Coverage is limited to 36 visits per benefit period.*		
Office	$40 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Dialysis/Hemodialysis		
Office	$40 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Outpatient Hospital	25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Chemo/Radiation Therapy		
Office	$40 copay per visit medical deductible does not apply‡	50% coinsurance after medical deductible is met
Outpatient Hospital	25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Coverage for Skilled Nursing and Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 90 days combined per benefit period.*	25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Inpatient Hospice	25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Durable Medical Equipment	25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Out-of-Pocket Limit	$2,500 Person $5,000 Family	Not applicable
Prescription Drug Coverage **Network:** Base Network **Drug List: National** *Drugs not included on the drug list will not be covered.*		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Rx Maintenance 90 Pharmacy** *90 day supply (after 2 courtesy 30-day fills you will be required to purchase maintenance medications in 90-day fills at a M90 pharmacy or home delivery).* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail Order. You will need to call us on the number on your ID card to sign up when you first use the service.* **Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy. Drug cost share assistance programs may be available for certain specialty drugs.*		
Tier 1 - Typically Generic	$15 copay per prescription (retail) and $30 copay per prescription (home delivery)	Not applicable
Tier 2 – Typically Preferred Brand	$70 copay per prescription (retail) and $140 copay per prescription (home delivery)	Not applicable
Tier 3 - Typically Non-Preferred Brand	$90 copay per prescription (retail) and $180 copay per prescription (home delivery)	Not applicable
Specialty Medications (brand and generic)	$90 copay per prescription	No coverage

Notes:

- Dependent age: to end of the month in which the child attains age 26.
- 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.
- 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.
- The Primary Care Physician and Specialist office visit copay applies to both office and facility based office visits for evaluation and management services only.

- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- ‡ Your cost share will be reduced when services are provided in a PCP's office.
- If you have received Urgent Care at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services" which is generally coinsurance or coinsurance after your deductible is met.
- Ohio's House Bill 388 and the Federal No Surprises Act establish patient protections including from Out-of-Network Providers' surprise bills ("balance billing") for Emergency Care and other specified items or services. We will comply with these new state and federal requirements including how we process claims from certain Out-of-Network Providers.

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.