



2025 RENEWAL  
ASHLAND COUNTY



County Employee Benefit  
Consortium of Ohio

**CEBCO**

*Health & Wellness*

# Your summary of benefits



## CEBCO

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access CEBCO **Ashland County PPO Plan 2D** – Wellness Plan

Your Network: Blue Access

Effective Date: 1/1/2025

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge medical deductible does not apply
Mental Health & Substance Use Disorder Services	No charge medical deductible does not apply
Specialist care	\$40 copay per visit medical deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-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
<p>EMBEDDED: 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.</p> <p>All medical deductibles, copayments and coinsurance apply to the out-of-pocket limit(s).</p> <p>In-Network and Out-of-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.</p>		
<b>Doctor Visits (virtual and office)</b> <i>You are encouraged to select a Primary Care Physician (PCP).</i>		
<b>Primary Care (PCP) and Mental Health and Substance Use Disorder Services</b> <i>virtual and office</i>	\$20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
<b>Specialist Care</b> <i>virtual and office</i>	\$40 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
<b><u>Other Practitioner Visits</u></b>		
<b>Maternity Doctor services</b> (prenatal/postnatal care and delivery)	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 an Out-of-Network Provider
<b>Retail Health Clinic</b> <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i>	\$20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
<b><u>Other Services in an Office</u></b>  <b>Allergy Testing</b> <i>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.</i>  <b>Prescription Drugs</b> <i>Dispensed in the office</i>  <b>Surgery</b>	25% coinsurance after medical deductible is met  25% coinsurance after medical deductible is met  \$40 copay per visit medical deductible does not apply <sup>†</sup>	50% coinsurance after medical deductible is met  50% coinsurance after medical deductible is met  50% coinsurance after medical deductible is met
<b>Preventive care / screenings / immunizations</b>	No charge	50% coinsurance after medical deductible is met
<b>Preventive Care for Chronic Conditions</b> <i>per IRS guidelines</i>	No charge	50% coinsurance after deductible is met
<b><u>Diagnostic Services</u></b>  <b>Lab</b>  Office   Outpatient Hospital	No charge   25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met   50% coinsurance after medical deductible is met
<b>X-Ray</b>  Office   Outpatient Hospital	No charge   25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met   50% coinsurance after medical deductible is met
<b>Advanced Diagnostic Imaging</b> <i>for example: MRI, PET and CAT scans</i>  Office	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 an Out-of-Network Provider
Outpatient Hospital	25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
<u><b>Emergency and Urgent Care</b></u> <b>Urgent Care</b> <i>includes doctor services. Additional charges may apply depending on the care provided.</i>  <b>Emergency Room Facility Services</b> <i>Your copay will be waived if admitted.</i>  <b>Emergency Room Doctor and Other Services</b>  <b>Ambulance</b>	\$50 copay per visit medical deductible does not apply  \$250 copay per visit and 0% coinsurance medical deductible does not apply  0% coinsurance medical deductible does not apply  25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met  Covered as In-Network  Covered as In-Network  Covered as In-Network
<b>Outpatient Mental Health and Substance Use Disorder Services at a Facility</b>  Facility Fees   Doctor Services	25% coinsurance after medical deductible is met  25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met  50% coinsurance after medical deductible is met
<u><b>Outpatient Surgery</b></u> <b>Facility Fees</b> Hospital  <b>Physician and other services</b> <i>including surgeon fees</i> Hospital	25% coinsurance after medical deductible is met  25% coinsurance after medical deductible is met	50% 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 an Out-of-Network Provider
<b><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u></b>  <b>Facility Fees</b>  <b>Human Organ and Tissue Transplants</b> <i>Cornea transplants are treated the same as any other illness and subject to the medical benefits.</i>  <b>Physician and other services</b> <i>including surgeon fees</i>	25% coinsurance after medical deductible is met  25% coinsurance after medical deductible is met  25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met  50% coinsurance after medical deductible is met  50% coinsurance after medical deductible is met
<b>Home Health Care</b> <i>Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.</i>	25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
<b>Rehabilitation and Habilitation services</b> <i>including physical, occupational and speech therapies.</i> <i>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.</i>  Office  Outpatient Hospital  <b>Manipulation Therapy</b> <i>Coverage is limited to 12 visits per benefit period.</i>  Office  Outpatient Hospital	\$40 copay per visit medical deductible does not apply  25% coinsurance after medical deductible is met  \$40 copay per visit medical deductible does not apply  25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met  50% coinsurance after medical deductible is met  50% coinsurance after medical deductible is met  50% coinsurance after medical deductible is met
<b>Pulmonary rehabilitation</b> <i>Coverage is limited to 20 visits per benefit period.</i>  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 an Out-of-Network Provider
Outpatient Hospital	25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
<b>Cardiac rehabilitation</b> <i>Coverage is limited to 36 visits per benefit period.</i> Office Outpatient Hospital	\$40 copay per visit medical deductible does not apply 25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met 50% coinsurance after medical deductible is met
<b>Dialysis/Hemodialysis</b> Office Outpatient Hospital	\$40 copay per visit medical deductible does not apply 25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met 50% coinsurance after medical deductible is met
<b>Chemo/Radiation Therapy</b> Office Outpatient Hospital	\$40 copay per visit medical deductible does not apply <sup>†</sup> 25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met 50% coinsurance after medical deductible is met
<b>Skilled Nursing Care (facility)</b> <i>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.</i>	25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
<b>Inpatient Hospice</b>	25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
<b>Durable Medical Equipment</b>	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 an Out-of-Network Provider
<b>Prosthetic Devices</b> <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	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 an Out-of-Network Pharmacy
Pharmacy Out-of-Pocket Limit	\$2,500 Person \$5,000 Family	Not applicable
<b>Prescription Drug Coverage</b> <b>Network: <i>Base Network</i></b> <b>Drug List: <i>National</i></b> <i>Drugs not included on the drug list will not be covered.</i>		
<b>Day Supply Limits:</b> <b>Retail Pharmacy</b> <i>30 day supply (cost shares noted below)</i> <b>Rx Maintenance 90 Pharmacy</b> <i>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).</i> <b>Home Delivery Pharmacy</b> <i>90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.</i> <b>Specialty Pharmacy</b> <i>30 day supply (cost shares noted below for retail and home delivery apply). We may 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.</i>		
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 Limit: to the end of the month in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using Out-of-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 an Out-of-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.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
- ‡ You will pay the PCP's office visit copay when services are provided in their 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.
- The representations of benefits in this document are subject to Ohio Department of Insurance (ODI) approval and are subject to change.

*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.*

Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company. Independent licensee of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Questions: (833) 639-1634 or visit us at [www.anthem.com](http://www.anthem.com)

# Your summary of benefits



## CEBCO

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access CEBCO **Ashland County PPO Plan 5D** – Standard Plan

Your Network: Blue Access

Effective Date: 1/1/2025

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge medical deductible does not apply
Mental Health & Substance Use Disorder Services	No charge medical deductible does not apply
Specialist care	\$50 copay per visit medical deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	\$2,000 person / \$4,000 family	\$4,000 person / \$8,000 family
Overall Out-of-Pocket Limit	\$4,750 person / \$9,500 family	\$9,500 person / \$19,000 family
<p>EMBEDDED: 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.</p> <p>All medical deductibles, copayments and coinsurance apply to the out-of-pocket limit(s).</p> <p>In-Network and Out-of-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.</p>		
<b>Doctor Visits (virtual and office)</b> <i>You are encouraged to select a Primary Care Physician (PCP).</i>		
<b>Primary Care (PCP) and Mental Health and Substance Use Disorder Services</b> <i>virtual and office</i>	\$25 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
<b>Specialist Care</b> <i>virtual and office</i>	\$50 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
<b><u>Other Practitioner Visits</u></b>		
<b>Maternity Doctor services</b> (prenatal/postnatal care and delivery)	50% 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 an Out-of-Network Provider
<b>Retail Health Clinic</b> <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i>	\$25 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
<b><u>Other Services in an Office</u></b>  <b>Allergy Testing</b> <i>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.</i>  <b>Prescription Drugs</b> <i>Dispensed in the office</i>  <b>Surgery</b>	50% coinsurance after medical deductible is met  50% coinsurance after medical deductible is met  \$50 copay per visit medical deductible does not apply <sup>†</sup>	50% coinsurance after medical deductible is met  50% coinsurance after medical deductible is met  50% coinsurance after medical deductible is met
<b>Preventive care / screenings / immunizations</b>	No charge	50% coinsurance after medical deductible is met
<b>Preventive Care for Chronic Conditions</b> <i>per IRS guidelines</i>	No charge	50% coinsurance after deductible is met
<b><u>Diagnostic Services</u></b>  <b>Lab</b>  Office   Outpatient Hospital	No charge   50% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met   50% coinsurance after medical deductible is met
<b>X-Ray</b>  Office   Outpatient Hospital	No charge   50% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met   50% coinsurance after medical deductible is met
<b>Advanced Diagnostic Imaging</b> <i>for example: MRI, PET and CAT scans</i>  Office	50% 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 an Out-of-Network Provider
Outpatient Hospital	50% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
<b><u>Emergency and Urgent Care</u></b> <b>Urgent Care</b> <i>includes doctor services. Additional charges may apply depending on the care provided.</i>  <b>Emergency Room Facility Services</b> <i>Your copay will be waived if admitted.</i>  <b>Emergency Room Doctor and Other Services</b>   <b>Ambulance</b>	 \$50 copay per visit medical deductible does not apply  \$250 copay per visit and 0% coinsurance medical deductible does not apply  0% coinsurance medical deductible does not apply  50% coinsurance after medical deductible is met	 50% coinsurance after medical deductible is met  Covered as In-Network   Covered as In-Network  Covered as In-Network
<b>Outpatient Mental Health and Substance Use Disorder Services at a Facility</b>  Facility Fees   Doctor Services	  50% coinsurance after medical deductible is met   50% coinsurance after medical deductible is met	  50% coinsurance after medical deductible is met   50% coinsurance after medical deductible is met
<b><u>Outpatient Surgery</u></b> <b>Facility Fees</b> Hospital  <b>Physician and other services</b> <i>including surgeon fees</i> Hospital	  50% coinsurance after medical deductible is met   50% coinsurance after medical deductible is met	  50% 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 an Out-of-Network Provider
<b><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u></b>  <b>Facility Fees</b>  <b>Human Organ and Tissue Transplants</b> <i>Cornea transplants are treated the same as any other illness and subject to the medical benefits.</i>  <b>Physician and other services</b> <i>including surgeon fees</i>	50% coinsurance after medical deductible is met  50% coinsurance after medical deductible is met  50% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met  50% coinsurance after medical deductible is met  50% coinsurance after medical deductible is met
<b>Home Health Care</b> <i>Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.</i>	50% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
<b>Rehabilitation and Habilitation services</b> <i>including physical, occupational and speech therapies.</i> <i>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.</i>  Office  Outpatient Hospital  <b>Manipulation Therapy</b> <i>Coverage is limited to 12 visits per benefit period.</i>  Office  Outpatient Hospital	\$50 copay per visit medical deductible does not apply  50% coinsurance after medical deductible is met  50% coinsurance after medical deductible is met  \$50 copay per visit medical deductible does not apply  50% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met  50% coinsurance after medical deductible is met  50% coinsurance after medical deductible is met  50% coinsurance after medical deductible is met
<b>Pulmonary rehabilitation</b> <i>Coverage is limited to 20 visits per benefit period.</i>  Office	\$50 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 an Out-of-Network Provider
Outpatient Hospital	50% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
<b>Cardiac rehabilitation</b> <i>Coverage is limited to 36 visits per benefit period.</i> Office Outpatient Hospital	\$50 copay per visit medical deductible does not apply 50% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met 50% coinsurance after medical deductible is met
<b>Dialysis/Hemodialysis</b> Office Outpatient Hospital	\$50 copay per visit medical deductible does not apply 50% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met 50% coinsurance after medical deductible is met
<b>Chemo/Radiation Therapy</b> Office Outpatient Hospital	\$50 copay per visit medical deductible does not apply <sup>†</sup> 50% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met 50% coinsurance after medical deductible is met
<b>Skilled Nursing Care (facility)</b> <i>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.</i>	50% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
<b>Inpatient Hospice</b>	50% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
<b>Durable Medical Equipment</b>	50% 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 an Out-of-Network Provider
<b>Prosthetic Devices</b> <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	50% 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 an Out-of-Network Pharmacy
Pharmacy Out-of-Pocket Limit	\$2,500 Person \$5,000 Family	Not applicable
<b>Prescription Drug Coverage</b> <b>Network: <i>Base Network</i></b> <b>Drug List: <i>National</i></b> <i>Drugs not included on the drug list will not be covered.</i>		
<b>Day Supply Limits:</b> <b>Retail Pharmacy</b> <i>30 day supply (cost shares noted below)</i> <b>Rx Maintenance 90 Pharmacy</b> <i>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).</i> <b>Home Delivery Pharmacy</b> <i>90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.</i> <b>Specialty Pharmacy</b> <i>30 day supply (cost shares noted below for retail and home delivery apply). We may 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.</i>		
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 Limit: to the end of the month in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using Out-of-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 an Out-of-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.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
- ‡ You will pay the PCP's office visit copay when services are provided in their 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.
- The representations of benefits in this document are subject to Ohio Department of Insurance (ODI) approval and are subject to change.

*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.*

Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company. Independent licensee of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Questions: (833) 639-1634 or visit us at [www.anthem.com](http://www.anthem.com)