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 1/1/2027

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
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. All medical deductibles, copayments and coinsurance apply to the out-of-pocket limit (excluding Out-of-Network Human Organ and Tissue Transplant (HOTT), Cellular and Gene Therapy services). In-Network and Out-of-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).*		
Primary Care (PCP) *virtual and office*	$20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Mental Health and Substance Use Disorder Services *virtual and office*	$20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Specialist Provider *virtual and office*	$40 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Other Practitioner Visits		
Maternity Doctor services (prenatal/postpartum 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
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
Other Services in an Office		
Allergy Testing	25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Allergy Injections	$5 copay per visit medical deductible does not apply	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
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
Diagnostic Services 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
Diagnostic Services 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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
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 *Your copay will be 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 Use Disorder Services 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
Physician and other services *including surgeon fees*		
Hospital	25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)		
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 as medical procedures, with benefits and cost sharing determined by the setting in which the services are received. You must get certain covered transplant procedures from an Approved In-Network Provider to receive the In-Network level of benefits.*	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
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
Therapy Services **Rehabilitation and Habilitation services** *Coverage for **Physical and Occupational Therapies** is limited to 30 visits each per benefit period.*		
Office	$20 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
*Coverage for **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
Manipulation Therapy *Coverage is limited to 12 visits per benefit period.*		
Office	$20 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.*		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
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
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 is limited to 90 days per benefit period. Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 60 days 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	25% coinsurance after medical deductible is met
Additional Services, Equipment and Devices		
Durable Medical Equipment	25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Prosthetic Devices	25% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Wigs *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
Hearing Aids (for members through age 21) *Coverage is limited to 1 hearing aid per hearing impaired ear every 48 months including wearable and bone anchored hearing aids with a dollar maximum of $2,500 per ear.*	No charge	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 Deductible	Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit	$2,500 person / $5,000 family	$2,500 person / $5,000 family
Prescription Drug Coverage **Network:** ***Base Network*** **Drug List:** ***National*** ***For more information, refer to "National Drug List" at*** *https://www.anthem.com/pharmacy-information/.*		
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 RXM90 pharmacy or home delivery.)* **Home Delivery Pharmacy:** *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.* **Specialty Pharmacy:** *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.*		
Tier 1 - Typically Generic	$15 copay per prescription (retail) and $30 copay per prescription (home delivery)	$15 copay per prescription (retail) and Not covered (home delivery)
Tier 2 - Typically Preferred Brand	$70 copay per prescription (retail) and $140 copay per prescription (home delivery)	$70 copay per prescription (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand & Specialty	$90 copay per prescription (retail) and $180 copay per prescription (home delivery)	$90 copay per prescription (retail) and Not covered (home delivery & Specialty)

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 your PCP or Specialist office visit copay for certain services 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.

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