

CEBCO Lawrence County Plan 3b – County Option 2 Blue AccessSM (PPO) Summary of Benefits

Effective 01/01/2021

Covered Benefits	Network	Non-Network
Deductible (Single/Family)	\$750/\$1,500	\$2,000/\$4,000
Out-of-Pocket Limit (Single/Family)	\$2,500/\$5,000	\$5,000/\$10,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/Specialty Care Physician (SCP) Including Office Surgeries and allergy serum:	\$20/\$40	40%
<ul style="list-style-type: none"> allergy injections (PCP and SCP) 	\$5	40%
<ul style="list-style-type: none"> allergy testing 	20%	40%
<ul style="list-style-type: none"> routine and non-routine mammograms (regardless of outpatient setting) 	No copayment/coinsurance	40%
<ul style="list-style-type: none"> diabetic education (regardless of outpatient setting) 	No copayment/coinsurance	40%
<ul style="list-style-type: none"> certain medical nutritional therapy (regardless of outpatient setting) 	No copayment/coinsurance	Not Covered
<ul style="list-style-type: none"> MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies and non-maternity related Ultrasounds 	20%	40%
<ul style="list-style-type: none"> LiveHealth Online (Telehealth) Medical visits 	\$0	Not Covered
Preventive Care Services Services include but are not limited to: Routine Exams, Pelvic Exams, Pap testing, PSA tests, Immunizations ¹ , Annual diabetic eye exam, Routine Vision and Hearing exams		
<ul style="list-style-type: none"> Physician Home and Office Visits (PCP/SCP) 	No copayment/coinsurance	40%
<ul style="list-style-type: none"> Other Outpatient Services @ Hospital/Alternative Care Facility 	No copayment/coinsurance	40%
Emergency (ER)⁵ and Urgent Care		
<ul style="list-style-type: none"> Emergency Room Services @ Hospital (facility/other covered services) (copayment waived if admitted) 	\$200	\$200
<ul style="list-style-type: none"> Urgent Care Center Services 	\$50	\$50
Inpatient and Outpatient Professional Services Include but are not limited to:	20%	40%
<ul style="list-style-type: none"> Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams 		
<ul style="list-style-type: none"> For certain surgeries, facilities with BDC+ distinction (knee/hip replacement, cardiac and spine)⁴ 	10%	Not applicable
Inpatient Facility Services Unlimited days except for:	20%	40%
<ul style="list-style-type: none"> 60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) 		
<ul style="list-style-type: none"> 90 days Network/Non-Network combined for skilled nursing facility 		
<ul style="list-style-type: none"> For certain surgeries, facilities with BDC+ distinction (knee/hip replacement, cardiac and spine)⁴ 	10%	Not applicable
Outpatient Surgery Hospital/Alternative Care Facility	20%	40%
<ul style="list-style-type: none"> Surgery and administration of general anesthesia 		
Other Outpatient Services (including but not limited to):		
<ul style="list-style-type: none"> Non Surgical Outpatient Services for example: MRIs, C-Scans, Chemotherapy, Ultrasounds, and other diagnostic outpatient services. 	20%	40%
<ul style="list-style-type: none"> Home Care Services (Network/Non-network combined) 90 visits (excludes IV Therapy) 	20%	40%
<ul style="list-style-type: none"> Durable Medical Equipment, Orthotics and Prosthetic Devices 	20%	40%
<ul style="list-style-type: none"> Physical Medicine Therapy Day Rehabilitation programs 	20%	40%
<ul style="list-style-type: none"> Hospice Care 	20%	20%
<ul style="list-style-type: none"> Ambulance Services 	20%	20%

Covered Benefits	Network	Non-Network
Outpatient Therapy Services (Combined Network & Non-Network limits apply) <ul style="list-style-type: none"> Physician Home and Office Visits (PCP/SCP) Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: Physical Medicine Therapy Limits, Outpatient Therapy (Network and Non-Network combined): <ul style="list-style-type: none"> Physical therapy: 30 visits Occupational therapy: 30 visits Manipulation therapy: 12 visits Speech therapy: 20 visits 	\$20/\$40 20%	40% 40%
Behavioral Health Services: Mental Health and Substance Abuse² <ul style="list-style-type: none"> Inpatient Facility Services Inpatient Professional Services Physician Home and Office Visits (PCP/SCP) Other Outpatient Services @ Hospital/Alternative Care Facility <i>These benefits have been tested and are compliant with Federal Mental Health Parity legislation.</i>	20% 20% \$20 20%	40% 40% 40% 40%
Human Organ and Tissue Transplants³ <ul style="list-style-type: none"> Acquisition and transplant procedures, harvest and storage. 	No copayment/coinsurance	50%
Prescription Drugs <ul style="list-style-type: none"> Separate Out of Pocket Maximum: \$2,500 Single/\$5,000 Family 	Retail (30 Day Supply) Tier 1: \$ 4 Tier 2: \$30 Tier 3: \$50	Mail Order (90 Day Supply) Tier 1: \$ 10 Tier 2: \$ 60 Tier 3: \$100

Notes:

- All medical deductibles, copayments, and coinsurance apply toward the out-of-pocket (excluding Prescription Drug cost share options and Non-network Human Organ and Tissue Transplant (HOTT) Services).
- Deductible(s) apply only to covered medical services listed with a percentage (%) coinsurance. However, the deductible does not apply to Emergency Room Services @ Hospital where a percentage (%) coinsurance applies to other covered services.
- Network and Non-network deductibles, copayments, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- 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/GYN's and Geriatrics or any other Network Provider as allowed by the plan.
- Physicians Home and office visit copayment also applies if the office visit is billed with allergy injections.
- 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.
- Benefit period = calendar year
- Private Duty Nursing limited to 82 visits/calendar year and 164 visits/lifetime

¹These covered services are not subject to the deductible/copayment if you have a flat dollar copayment and if rendered without an office visit.

²We encourage you to contact Our Mental Health Subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits for limitations.

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

⁴Blue Distinction Total Care+ (BDC+) facilities can be found on www.anthem.com, provider directory under Hospitals. Network benefits, facility and professional, will be paid at a higher level when knee/hip replacements, cardiac PCI and CBG surgeries and spine surgeries including discectomy, fusion and decompression procedures are performed at these facilities.

⁵Benefits may be denied for certain avoidable Emergency Room visits. See your certificate of benefits for details.

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.

Authorized Group Signature	Date
Underwriting Signature	Date