

# Your summary of benefits



## CEBCO

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access CEBCO Lawrence County PPO Plan 3b – County Option 2

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	\$750 person / \$1,500 family	\$2,000 person / \$4,000 family
Overall Out-of-Pocket Limit	\$2,500 person / \$5,000 family	\$5,000 person / \$10,000 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(s).

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).*

<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	40% coinsurance after medical deductible is met
<b>Specialist Care</b> <i>virtual and office</i>	\$40 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
<b><u>Other Practitioner Visits</u></b>		
<b>Maternity Doctor services</b> (prenatal/postnatal care and delivery)	20% coinsurance after medical deductible is met	40% 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> 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	40% coinsurance after medical deductible is met
<u><b>Other Services in an Office</b></u>  <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> Dispensed in the office  <b>Surgery</b>	20% coinsurance after medical deductible is met  20% coinsurance after medical deductible is met  \$40 copay per visit medical deductible does not apply <sup>‡</sup>	40% coinsurance after medical deductible is met  40% coinsurance after medical deductible is met  40% coinsurance after medical deductible is met
<b>Preventive care / screenings / immunizations</b>	No charge	40% coinsurance after medical deductible is met
<b>Preventive Care for Chronic Conditions</b> per IRS guidelines	No charge	40% coinsurance after deductible is met
<u><b>Diagnostic Services</b></u>  <b>Lab</b>  Office  Outpatient Hospital	No charge  20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met  40% coinsurance after medical deductible is met
<b>X-Ray</b>  Office  Outpatient Hospital	No charge  20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met  40% coinsurance after medical deductible is met
<b>Advanced Diagnostic Imaging</b> for example: MRI, PET and CAT scans  Office	20% coinsurance after medical deductible is met	40% 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	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<p><b><u>Emergency and Urgent Care</u></b></p> <p><b>Urgent Care</b> <i>includes doctor services. Additional charges may apply depending on the care provided.</i></p> <p><b>Emergency Room Facility Services</b> <i>Your copay will be waived if admitted.</i></p> <p><b>Emergency Room Doctor and Other Services</b></p> <p><b>Ambulance</b></p>	<p>\$50 copay per visit medical deductible does not apply</p> <p>\$200 copay per visit and 0% coinsurance medical deductible does not apply</p> <p>0% coinsurance medical deductible does not apply</p> <p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p><b>Outpatient Mental Health and Substance Use Disorder Services at a Facility</b></p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>
<p><b><u>Outpatient Surgery</u></b></p> <p><b>Facility Fees</b></p> <p>Hospital</p> <p><b>Physician and other services</b> <i>including surgeon fees</i></p> <p>Hospital</p>	<p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<p><b><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u></b></p> <p><b>Facility Fees</b></p> <p><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></p> <p><b>Physician and other services</b> <i>including surgeon fees</i></p>	<p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>
<p><b>Home Health Care</b> <i>Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.</i></p>	<p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p>
<p><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></p> <p>Office</p> <p>Outpatient Hospital</p> <p><b>Manipulation Therapy</b> <i>Coverage is limited to 12 visits per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$40 copay per visit medical deductible does not apply</p> <p>20% coinsurance after medical deductible is met</p> <p>\$40 copay per visit medical deductible does not apply</p> <p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>
<p><b>Pulmonary rehabilitation</b> <i>Coverage is limited to 20 visits per benefit period.</i></p> <p>Office</p>	<p>\$40 copay per visit medical deductible does not apply</p>	<p>40% coinsurance after medical deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Hospital	20% coinsurance after medical deductible is met	40% 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  20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met  40% coinsurance after medical deductible is met
<b>Dialysis/Hemodialysis</b>  Office  Outpatient Hospital	\$40 copay per visit medical deductible does not apply  20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met  40% 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>  20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met  40% 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>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<b>Inpatient Hospice</b>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<b>Durable Medical Equipment</b>	20% coinsurance after medical deductible is met	40% 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
<p><b>Prosthetic Devices</b>  <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i></p>	<p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p>

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 Drugs not included on the drug list will not be covered.</i></b>		
<b>Day Supply Limits:</b> <b>Retail Pharmacy</b> 30 day supply (cost shares noted below) <b>Rx Maintenance 90 Pharmacy</b> 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). <b>Home Delivery Pharmacy</b> 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. <b>Specialty Pharmacy</b> 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	\$4 copay per prescription (retail) and \$10 copay per prescription (home delivery)	Not applicable
Tier 2 - Typically Preferred Brand	\$30 copay per prescription (retail) and \$60 copay per prescription (home delivery)	Not applicable
Tier 3 - Typically Non-Preferred Brand	\$50 copay per prescription (retail) and \$100 copay per prescription (home delivery)	Not applicable
Specialty Medications (brand and generic)	\$50 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.*

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