

Your Anthem Benefits



CEBCO Standard Plan 5B-Sandusky County/with RX/Blue Access PPO Summary of Benefits Effective 01/01/2018

Covered Benefits	Network	Non-Network
Deductible (Single/Family)	\$1,000/\$2,000	\$3,000/\$6,000
Out-of-Pocket Limit (Single/Family)	\$4,000/\$8,000	\$6,000/\$12,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/Specialty Care Physician (SCP) Including Office Surgeries and allergy serum:	\$20/\$40	50%
<ul style="list-style-type: none"> allergy injections (PCP and SCP) allergy testing routine and non-routine mammograms (regardless of outpatient setting) diabetic education (regardless of outpatient setting) certain medical nutritional therapy (regardless of outpatient setting) MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies and non-maternity related Ultrasounds LiveHealth Online (Telehealth) Medical visits 	\$5 50% No copayment/coinsurance No copayment/coinsurance 50% No copayment/coinsurance	50% 50% 50% 50% Not Covered 50% 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) Other Outpatient Services @ Hospital/Alternative Care Facility 	No copayment/coinsurance No copayment/coinsurance	50% 50%
Emergency (ER)⁵ and Urgent Care		
<ul style="list-style-type: none"> Emergency Room Services @ Hospital (facility/other covered services) (copayment waived if admitted) Urgent Care Center Services 	\$200 \$50	\$200 \$50
Inpatient and Outpatient Professional Services Include but are not limited to:	50%	50%
<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 		
Inpatient Facility Services Unlimited days except for:	50%	50%
<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) 90 days Network/Non-Network combined for skilled nursing facility For certain surgeries, facilities with BDC+ distinction; includes professional services (knee/hip replacement, cardiac and spine)⁴ 	40%	Not applicable
Outpatient Surgery Hospital/Alternative Care Facility	50%	50%
<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. Home Care Services (Network/Non-network combined) 90 visits (excludes IV Therapy) Durable Medical Equipment, Orthotics and Prosthetic Devices Physical Medicine Therapy Day Rehabilitation programs Hospice Care Ambulance Services 	50% 50% 50% 50% 50% 50%	50% 50% 50% 50% 50% 50%

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 (Excludes Autism Spectrum Disorder) (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 50%	50% 50%
Behavioral Health Services: Mental Health and Substance Abuse² <ul style="list-style-type: none"> Inpatient Professional/Facility Services Physician Home and Office Visits (PCP/SCP) Other Outpatient Services @ Hospital/Alternative Care Facility These benefits have been tested and are compliant with Federal Mental Health Parity legislation.	05% \$20 50%	50% 50% 50%
Human Organ and Tissue Transplants³ <ul style="list-style-type: none"> Acquisition and transplant procedures, harvest and storage. 	No copayment/coinsurance	50%
Prescription Drugs through RxOC/Express Scripts Out of pocket Maximum \$2,500 Single/\$5,000 Family	Retail (30 day supply) Generic \$ 4 Preferred Brand \$ 35 Non-Preferred Brand \$ 70	Mail Order (90 day supply) Generic \$ 10 Preferred Brand \$ 70 Non-Preferred Brand \$140

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 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