Your Anthem Benefits

Anthem.

CEBCO Standard Plan 5B-Sandusky County Blue Access PPO
Summary of Benefits *Effective 01/01/2020*

Covered Benefits	Network	Non-Network
Deductible (Single/Family)	$1,000/$2,000	$3,000/$6,000
Out-of-Pocket Limit (Single/Family) **Includes deductible, coinsurance and co-pays**	$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%
• allergy injections (PCP and SCP)	$5	50%
• allergy testing	50%	50%
• routine and non-routine mammograms (regardless of outpatient setting)	No copayment/coinsurance	50%
• diabetic education (regardless of outpatient setting)	No copayment/coinsurance	50%
• certain medical nutritional therapy (regardless of outpatient setting)	No copayment/coinsurance	Not Covered
• MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies and non-maternity related Ultrasounds	50%	50%
• LiveHealth Online (Telehealth) **Medical visits**	No copayment/coinsurance	Not Covered
Preventive Care Services Services include but are not limited to: Routine Exams, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Routine Vision and Hearing exams		
• Physician Home and Office Visits (PCP/SCP)	No copayment/coinsurance	50%
• Other Outpatient Services @ Hospital/Alternative Care Facility	No copayment/coinsurance	50%
Emergency (ER) and Urgent Care		
• **Emergency Room Services @ Hospital (facility/other covered services)** *(copayment waived if admitted)*	$200	$200
• **Urgent Care Center Services**	$50	$50
Inpatient and Outpatient Professional Services Include but are not limited to:	50%	50%
• 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%
• 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)	40%	Not applicable
Outpatient Surgery Hospital/Alternative Care Facility	50%	50%
• Surgery and administration of general anesthesia		
Other Outpatient Services *(including but not limited to):*		
• Non-Surgical Outpatient Services for example: MRIs, C-Scans, Chemotherapy, Ultrasounds, and other diagnostic outpatient services.	50%	50%
• Home Care Services (Network/Non-network combined) 90 visits (excludes IV Therapy)	50%	50%
• Durable Medical Equipment, Orthotics and Prosthetic Devices	50%	50%
• Physical Medicine Therapy Day Rehabilitation programs	50%	50%
• Hospice Care	50%	50%
• Ambulance Services	50%	50%

Covered Benefits	Network	Non-Network
Outpatient Therapy Services **(Combined Network & Non-Network limits apply)** • 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): • 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 Abuse** • 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.***	50% $20 50%	50% 50% 50%
Human Organ and Tissue Transplants • Acquisition and transplant procedures, harvest and storage.	No copayment/coinsurance	50%
Prescription Drugs with Anthem RX **Out of pocket Maximum** **$2,500 Single/$5,000 Family**	**Retail (30 day supply)** **Tier 1 $ 4** **Tier 2 $ 35** **Tier 3 $ 70**	**Mail Order (90 day supply)** **Tier 1 $ 10** **Tier 2 $ 70** **Tier 3 $140**

This summary of benefits is a brief outline of coverage.
This does not reflect each and every benefit, exclusion or limitation which may apply to the coverage.
Pease refer to your Medical Benefit Booklet for more details.