Your summary of benefits

CEBCO/ SANDUSKY COUNTY Plan Year 2022
Your Plan: 5B-Standard Plan

Your Network: Blue Access

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use aNon-Network Provider
Overall Deductible	$ 1,000 person $ 2,000 family	$ 3,000 person $ 6,000 family
Out-of-Pocket Limit	$ 4,000 person $ 8,000 family	$ 6,000 person $ 12,000 family
The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.		
Preventive Care / Screening / Immunization	No charge	50% coinsurance after deductible is met
Doctor Home and Office Services **Primary Care Visit** *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.*	$20 copay per visit deductible does not apply	50% coinsurance after deductible is met
Specialist Care Visit *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.*	$40 copay per visit deductible does not apply	50% coinsurance after deductible is met
Prenatal and Postnatal Care	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Practitioner Visits:		
Virtual visits from Online Provider LiveHealth Online	No charge	Not Applicable
Retail Health Clinic	$20 copay per visit deductible does not apply	50% coinsurance after deductible is met
On-line Visit (includes telephone visits) *Includes Mental/Behavioral Health and Substance Abuse*	$20/40 copay per visit deductible does not apply	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Primary Care Provider On-line Visit (includes telephone visits) *Includes Mental/Behavioral Health and Substance Abuse*	$20 copay per visit deductible does not apply	50% coinsurance after deductible is met
Specialist Provider On-line Visit (Includes telephone visits)	$40 copay per visit deductible does not apply	50% coinsurance after deductible is met
Manipulation Therapy *(Chiropractic)* *Coverage is limited to 12 visits per benefit period.*	$40 copay per visit deductible does not apply	50% coinsurance after deductible is met
<u>Diagnostic Services</u> **Lab:**		
Office *(When billed by the physician with the office visit. **NOT billed** by a hospital lab.)*	No charge	50% coinsurance after deductible is met
Outpatient Hospital	50% coinsurance after deductible is met	50% coinsurance after deductible is met
LabCorp/Quest *Ordering physician must be contracting with Anthem*	No Charge	Not applicable
Advanced Diagnostic Imaging:		
Office	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	50% coinsurance after deductible is met	50% coinsurance after deductible is met
<u>Emergency and Urgent Care</u>		
Urgent Care *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.*	$50 copay per visit Deductible does not apply	50% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$200 copay per visit and 0% coinsurance deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	0%coinsurance Deductible does not apply	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Ambulance	50% coinsurance after deductible is met	Covered as In-Network
Outpatient Surgery		
Facility Fees:		
Hospital	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):		
Facility Fees	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Human Organ and Tissue Transplants *Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.*	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and other services	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services:		
Office *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. Limit is combined for rehabilitative and habilitative services.*	$40 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital *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. Limit is combined for rehabilitative and habilitative services.*	50% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Out of Pocket	$2,500 Person $5,000 Family	Not applicable
Prescription Drug Coverage Cost shares for drugs included on the National drug list appear below. Drugs not included on the National drug list will not be covered. Your plan uses the National Network. You may receive up to a 90 day supply of medication at Retail 90 (R90) pharmacies. **Home Delivery Pharmacy** Maintenance medication are available through Anthem/IngenioRx Home Delivery Pharmacy. You will need to call the Pharmacy Member Services number on the back of your ID card to sign up when you first use the service.		
Tier 1 - Typically Generic *30-day supply (retail pharmacy).* *90-day supply (home delivery and retailpharmacy)* *Some medications are not available to be dispensed in 90-day supply.*	$4 copay per prescription $10 copay per prescription	Not applicable
Tier 2 – Typically Preferred Brand *30-day supply (retail pharmacy).* *90-day supply (home delivery and retailpharmacy)* *Some medications are not available to be dispensed in 90-day supply.*	$35 copay per prescription $70 copay per prescription	Not applicable
Tier 3 - Typically Non-Preferred Brand *30-day supply (retail pharmacy).* *90-day supply (home delivery and retailpharmacy)* *Some medications are not available to be dispensed in 90-day supply.*	$70 copay per prescription $140 copay perprescription	Not applicable
SPECIALTY MEDICATIONS *(Must be obtained through IngenioRx Specialty Pharmacy)* Specialty medications are ONLY dispensed in 30-day supply	Tier 3 (30-day copay applies per prescription)	No coverage
Effective January 1, 2022, you will be required to purchase maintenance medications in 90-day fill after two 30-day fills. (90-day fills may be obtained at retail orthru home delivery.)		

Notes:

- Dependent age: to end of the month in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).
- 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 a Non-network provider, the member is responsible for any balance due after the plan payment.
- If your plan includes out-of-network benefits, In-network and out-of-network deductibles, copayments, coinsurance and out-of-pocket maximum amounts are separate and do not accumulate toward each other.
- 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.
- ‡ Your cost share may be reduced when services are provided in a PCP's office.
- If you receive 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.

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.

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.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date