

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access PPO HSA 6200/0%/8000 E Rx Ded/0%/10%

Your Network: Blue Access

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge after deductible is met
Mental Health & Substance Use Disorder Services	No charge after deductible is met
Specialist care	No charge after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	\$6,200 person / \$12,400 family	\$18,600 person / \$37,200 family
Overall Out-of-Pocket Limit	\$8,000 person / \$16,000 family	\$24,000 person / \$48,000 family
<p>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.</p> <p>All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit (excluding Out-of-Network Human Organ and Tissue Transplant (HOTT), Cellular and Gene Therapy services).</p> <p>In-Network and Out-of-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.</p>		
Doctor Visits (virtual and office) <i>You are encouraged to select a Primary Care Physician (PCP).</i>		
Primary Care (PCP) and Mental Health and Substance Use Disorder Services <i>virtual and office</i>	No charge after deductible is met	30% coinsurance after deductible is met
Specialist Provider <i>virtual and office</i>	No charge after deductible is met	30% coinsurance after deductible is met
Other Practitioner Visits		
Maternity Doctor services (prenatal/postpartum care and delivery)	No charge after deductible is met	30% coinsurance after deductible is met
Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i>	No charge after deductible is met	30% coinsurance after deductible is met
Other Services in an Office		
Allergy Testing	No charge after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Prescription Drugs <i>Dispensed in the office</i> Surgery	No charge after deductible is met No charge after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	30% coinsurance after deductible is met
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	Cost share is based on the setting services are received.
<u>Diagnostic Services</u> Lab Office Outpatient Hospital	No charge after deductible is met No charge after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met
<u>Diagnostic Services</u> X-Ray Office Outpatient Hospital	No charge after deductible is met No charge after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met
<u>Diagnostic Services</u> Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i> Office Outpatient Hospital	No charge after deductible is met No charge after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met
<u>Emergency and Urgent Care</u> Urgent Care Emergency Room Facility Services Emergency Room Doctor and Other Services Ambulance <i>Authorized Out-of-Network non-emergency ambulance services are limited to an Anthem maximum payment of \$50,000 per trip. The \$50,000 limit does not apply to air ambulance services.</i>	No charge after deductible is met No charge after deductible is met No charge after deductible is met No charge after deductible is met	30% coinsurance after deductible is met Covered as In-Network Covered as In-Network Covered as In-Network
<u>Outpatient Mental Health and Substance Use Disorder Services at a Facility</u> Facility Fees Doctor Services	No charge after deductible is met No charge after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<p><u>Outpatient Surgery</u></p> <p>Facility Fees Hospital</p> <p>Physician and other services <i>including surgeon fees</i> Hospital</p>	<p>No charge after deductible is met</p> <p>No charge after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u></p> <p>Facility Fees</p> <p>Human Organ and Tissue Transplants <i>Cornea transplants are treated as medical procedures, with benefits and cost sharing determined by the setting in which the services are received. You must get certain covered transplant procedures from an Approved In-Network Provider to receive the In-Network level of benefits.</i></p> <p>Physician and other services <i>including surgeon fees</i></p>	<p>No charge after deductible is met</p> <p>No charge after deductible is met</p> <p>No charge after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><u>Home Health Care</u> <i>Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.</i></p>	<p>No charge after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p><u>Therapy Services</u></p> <p>Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies.</i> <i>Coverage for physical, occupational, and speech therapies is limited to 20 visits each per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p> <p>Manipulation Therapy <i>office and outpatient hospital</i> <i>Coverage is limited to 12 visits per benefit period.</i></p>	<p>No charge after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p>Pulmonary rehabilitation <i>office and outpatient hospital</i> <i>Coverage is limited to 20 visits per benefit period.</i></p>	<p>No charge after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p>Cardiac rehabilitation <i>office and outpatient hospital</i> <i>Coverage is limited to 36 visits per benefit period.</i></p>	<p>No charge after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p>Dialysis/Hemodialysis <i>office and outpatient hospital</i></p>	<p>No charge after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p>Chemo/Radiation Therapy <i>office and outpatient hospital</i></p>	<p>No charge after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p>Skilled Nursing Care (facility)</p>	<p>No charge after deductible is met</p>	<p>30% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<i>Coverage for Skilled Nursing and Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 150 days combined per benefit period.</i>		
Inpatient Hospice	No charge after deductible is met	30% coinsurance after deductible is met
<u>Additional Services, Equipment and Devices</u>		
Durable Medical Equipment	No charge after deductible is met	30% coinsurance after deductible is met
Prosthetic Devices	No charge after deductible is met	30% coinsurance after deductible is met
Wigs <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	No charge after deductible is met	30% coinsurance after deductible is met
Hearing Aids (for members through age 21) <i>Coverage is limited to 1 item, up to \$2,500 per hearing-impaired ear, every 48 months.</i>	No charge after deductible is met	30% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with In-Network medical deductible	Combined with Out-of-Network medical deductible
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with In-Network medical out-of-pocket limit	Combined with Out-of-Network medical out-of-pocket limit

Prescription Drug Coverage

Network: Rx Choice Tiered Network

Drug List: Essential *Drugs not included on the Essential drug list will not be covered.*

Day Supply Limits:

Retail Pharmacy *30 day supply (cost shares noted below)*

Retail 90 Pharmacy *90 day supply (3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies noted below applies).*

Home Delivery Pharmacy *90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy. You may get two 30-day supply fills of the same maintenance medication at a retail pharmacy. Prior to your 3rd fill, you must call us on the number on your ID card and tell us if you would like to keep getting your maintenance medications from a retail pharmacy or if you would like to use home delivery. If you do not contact us, you will pay the full retail cost of any maintenance medication until you inform us of your decision.*

Specialty Pharmacy *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.*

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Tier 1 - Typically Generic	0% coinsurance after deductible is met (retail and home delivery)	10% coinsurance after deductible is met (retail only)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 - Typically Preferred Brand	0% coinsurance after deductible is met (retail and home delivery)	10% coinsurance after deductible is met (retail only)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	0% coinsurance after deductible is met (retail and home delivery)	10% coinsurance after deductible is met (retail only)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	0% coinsurance after deductible is met (retail and home delivery)	10% coinsurance after deductible is met (retail only)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
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This is a brief outline of your vision coverage. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out-of-pocket limit.

Children's Vision exam (up to age 19) <i>Limited to 1 exam per benefit period.</i>	No charge	\$0 copayment up to plan's Maximum Allowed Amount
Adult Vision exam (age 19 and older) <i>Limited to 1 exam per benefit period.</i>	No charge	Reimbursed Up to \$42

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.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- 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.

- 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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