Your Anthem Benefits

Anthem

CEBCO Sandusky County Plan 4b
Blue Access℠ (PPO)
Summary of Benefits, Effective 01/01/2014

Please note: As we receive additional guidance and clarification from the U.S. Department of Health and Human Services, we may be required to make additional changes to your benefits.

Covered Benefits	Network	Non-Network
Deductible (Single/Family)	$1,000 / $2,000	$3,000 / $6,000
Out-of-Pocket Limit (Single/Family) Includes Deductible	$3,000 / $6,000	$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	25%	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	25%	50%
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		
• Physician Home and Office Visits (PCP/SCP)	No copayment/coinsurance	50%
• Other Outpatient Services @ Hospital/Alternative Care Facility	No copayment/coinsurance	50%
Emergency 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: • Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams	25%	50%
Inpatient Facility Services Unlimited days except for: • 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	25%	50%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	25%	50%
Other Outpatient Services *(including but not limited to):*		
• Non Surgical Outpatient Services for example: MRIs, C-Scans, Chemotherapy, Ultrasounds, and other diagnostic outpatient services.	25%	50%
• Home Care Services (Network/Non-network combined) 90 visits (excludes IV Therapy)	25%	50%
• Durable Medical Equipment and Orthotics	25%	50%
• Prosthetic Devices	25%	50%
• Physical Medicine Therapy Day Rehabilitation programs	25%	50%
• Hospice Care	25%	25%
• Ambulance Services	25%	25%

Covered Benefits	Network	Non-Network
Outpatient Therapy Services (Combined Network & Non-Network limits apply)		
• Physician Home and Office Visits (PCP/SCP)	$20/$40	50%
• Other Outpatient Services @ Hospital/Alternative Care Facility	25%	50%
Limits apply to:		
• Physical therapy: 30 visits		
• Occupational therapy: 30 visits		
• Manipulation therapy: 12 visits		
• Speech therapy: 20 visits		
Behavioral Health Services: Mental Health and Substance Abuse[2]		
• Inpatient Facility Services	25%	50%
• Inpatient Professional Services	25%	50%
• Physician Home and Office Visits	$20	50%
• Other Outpatient Services @ Hospital/Alternative Care Facility	25%	50%
Human Organ and Tissue Transplants[3]	No copayment/coinsurance	50%
• Acquisition and transplant procedures, harvest and storage.		
Prescription Drugs	Covered under separate plan	Covered under separate plan

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 the 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*

[1]*These covered services are not subject to the deductible/copayment if you have a flat dollar copayment and if rendered without an office visit.*
[2]*We 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.*
[3]*Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.*

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.*

Pre-existing Exclusion Period: None

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.