Your summary of benefits

Plan Year: 2022

Your Plan: CEBCO PPO Fayette County 1500A 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	$ 1,500 person $ 3,000 family	$ 3,000 person $ 5,000 family
Out-of-Pocket Limit	$ 4,500 person $ 9,000 family	$ 6,500 person $ 13,000 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	40% coinsurance after deductible is met
<u>Doctor Home and Office Services</u> **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	40% 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	40% coinsurance after deductible is met
Prenatal and Postnatal Care	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<u>Other Practitioner Visits:</u>		
Virtual visits from Online Provider LiveHealth Online	No charge	Not Applicable
Retail Health Clinic	$20 copay per visit deductible does not apply	40% 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	40% 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	40% coinsurance after deductible is met
Specialist Provider On-line Visit (Includes telephone visits)	$40 copay per visit deductible does not apply	40% 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	40% 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	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
LabCorp/Quest *Ordering physician must be contracting with Anthem*	No Charge	Not applicable
Advanced Diagnostic Imaging:		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% 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	40% 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	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Surgery		
Facility Fees:		
Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):		
Facility Fees	20% coinsurance after deductible is met	40% 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.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	40% 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.*	$20/$40 copay per visit deductible does not apply	40% 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.*	20% coinsurance after deductible is met	40% 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 retail pharmacy)* *Some medications are not available to be dispensed in 90-day supply.*	$15 copay per prescription $30 copay per prescription	Not applicable
Tier 2 – Typically Preferred Brand *30-day supply (retail pharmacy).* *90-day supply (home delivery and retail pharmacy)* *Some medications are not available to be dispensed in 90-day supply.*	$70 copay per prescription $140 copay per prescription	Not applicable
Tier 3 - Typically Non-Preferred Brand *30-day supply (retail pharmacy).* *90-day supply (home delivery and retail pharmacy)* *Some medications are not available to be dispensed in 90-day supply.*	$90 copay per prescription $180 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.)		