

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: **Franklin County Fiscal Court - PPO \$2500**

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 medical deductible does not apply
Mental Health & Substance Use Disorder Services	No charge medical deductible does not apply
Specialist care	\$60 copay per visit medical deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	\$2,500 person / \$5,000 family	\$5,000 person / \$10,000 family
Overall Out-of-Pocket Limit	\$8,000 person / \$16,000 family	\$16,000 person / \$32,000 family

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.

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).

In-Network and Out-of-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.

Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*

Preferred PCP <i>virtual and office</i> <i>(Providers reflected in our Find Care tool as: EPHC.)</i>	\$5 copay per visit medical deductible does not apply	Not covered
Primary Care (PCP) & Mental Health and Substance Use Disorder Services <i>virtual and office</i>	\$30 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Specialist Provider <i>virtual and office</i>	\$60 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met

Other Practitioner Visits

Maternity Doctor services (prenatal/postpartum care and delivery)	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i>	\$30 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Manipulation Therapy <i>Coverage is limited to 12 visits per benefit period.</i>	\$30 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met

Other Services in an Office

Allergy Testing <i>When Allergy injections are billed separately by network providers, the member is responsible for a \$10 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.</i>	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Prescription Drugs <i>Dispensed in the office</i>	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Surgery	\$60 copay per visit medical deductible does not apply [†]	50% coinsurance after medical deductible is met
Preventive care / screenings / immunizations	No charge	50% coinsurance after medical 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 Lab</u>		
Office	No charge	50% coinsurance after medical deductible is met
Freestanding Lab/Reference Lab	No charge	50% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
<u>Diagnostic Services X-Ray</u>		
Office	No charge	50% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
<u>Diagnostic Services Advanced Diagnostic Imaging</u> <i>for example: MRI, PET and CAT scans</i>		
Office	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Freestanding Radiology Center	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
<u>Emergency and Urgent Care</u>		
Urgent Care <i>includes doctor services. Additional charges may apply depending on the care provided.</i>	\$75 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Emergency Room Facility Services <i>Your copay will be waived if admitted.</i>	\$400 copay per visit medical deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	Covered as In-Network
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>	20% coinsurance after medical deductible is met	Covered as In-Network
<u>Outpatient Mental Health and Substance Use Disorder Services at a Facility</u>		
Facility Fees	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Doctor Services	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
<u>Outpatient Surgery</u>		
Facility Fees		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Ambulatory Surgical Center	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Physician and other services <i>including surgeon fees</i>		
Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Ambulatory Surgical Center	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
<u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u>		
Facility Fees	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
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>	No charge	50% coinsurance after medical deductible is met
Physician and other services <i>including surgeon fees</i>	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
<u>Home Health Care</u> <i>Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.</i>	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
<u>Therapy Services</u>		
Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies. You are responsible for cost shares no greater than the PCP office visit when Covered Services are performed by a Physical Therapist or Occupational Therapist.</i>		
<i>Coverage for physical and occupational therapies is limited to 20 visits combined per benefit period. Coverage for speech therapy is limited to 20 visits per benefit period.</i>		
Office	\$30 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Outpatient Hospital <i>Speech therapy by an In-Network Provider is subject to the following cost share instead of the one noted: 20% coinsurance after medical deductible is met</i>	\$30 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Pulmonary rehabilitation		
Office	\$60 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Cardiac rehabilitation <i>Coverage is limited to 36 visits per benefit period.</i>		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Office	\$60 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Dialysis/Hemodialysis		
Office	\$60 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Chemo/Radiation Therapy		
Office	\$60 copay per visit medical deductible does not apply [†]	50% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Skilled Nursing Care (facility) <i>Coverage for Skilled Nursing, Outpatient Rehabilitation and Inpatient Rehabilitation facility settings is limited to 150 days combined per benefit period.</i>	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Inpatient Hospice	No charge	No charge
<u>Additional Services, Equipment and Devices</u>		
Durable Medical Equipment	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Prosthetic Devices	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Wigs <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Hearing Aids <i>Coverage is limited to 1 item per ear every 36 months for members under 18 years of age.</i>	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Prescription Drug Benefits		Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible		Not applicable	Not applicable
Pharmacy 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: Base 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 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 will need to call us on the number on your ID card to sign up when you first use the service. 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.			
Tier 1 - Typically Generic		\$10 copay per prescription (retail) and \$30 copay per prescription (home delivery)	50% coinsurance (retail) and Not covered (home delivery)
Tier 2 - Typically Preferred Brand		\$40 copay per prescription (retail) and \$120 copay per prescription (home delivery)	50% coinsurance (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand		\$85 copay per prescription (retail) and \$255 copay per prescription (home delivery)	50% coinsurance (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)		25% coinsurance up to \$250 per prescription (retail and home delivery)	50% coinsurance (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
<i>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.</i>			
Children's Vision exam (up to age 21) <i>Limited to 1 exam per benefit period.</i>		No charge	\$0 copayment up to plan's Maximum Allowed Amount
Adult Vision exam (age 21 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, Specialist or Urgent Care 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.
- Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, 3D mammography, breast ultrasounds and MRIs are covered in full as required by state mandate.
- 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.
- * You will pay your PCP or Specialist office visit copay for certain services provided in their office.

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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