Your Anthem Benefits

CEBCO Williams County (Plan 2D) SILVER PLAN
Blue Access℠ (PPO)
Summary of Benefits

Effective 01/01/2018

Covered Benefits	Network	Non-Network
Deductible (Single/Family)	$800/$1,600	$1,600/$3,200
Out-of-Pocket Limit (Single/Family)	$3,200/$6,400	$6,400/$12,800
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%
• LiveHealth Online (Telehealth) Medical visits	$0	Not Covered
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 (ER)[5] and Urgent Care		
• **Emergency Room Services @ Hospital (facility/other covered services)** *(copayment waived if admitted)*	$250	$250
• **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%
• For certain surgeries, facilities with BDC+ distinction (knee/hip replacement, cardiac and spine)[4]	15%	Not applicable
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, Orthotics and Prosthetic Devices	25%	50%
• Physical Medicine Therapy Day Rehabilitation programs	25%	50%
• Hospice Care	25%	25%
• Ambulance Services	25%	25%

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Covered Benefits	Network	Non-Network
Outpatient Therapy Services **(Combined Network & Non-Network limits apply)** • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: Physical Medicine Therapy Limits, Outpatient Therapy (Excludes Autism Spectrum Disorder) (Network and Non-Network combined): • Physical therapy: 30 visits • Occupational therapy: 30 visits • Manipulation therapy: 12 visits • Speech therapy: 20 visits Autism Spectrum Disorder Services Outpatient Therapy Limits under age 14 (Network and Non-Network combined): • Occupational therapy: 30 visits • Speech therapy: 20 visits • Clinical Therapeutic Intervention services: 20 hours weekly	$20/$40 25%	50% 50%
Behavioral Health Services: **Mental Health and Substance Abuse[2]** • Inpatient Facility Services • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility ***These benefits have been tested and are compliant with Federal Mental Health Parity legislation.***	25% $20 25%	50% 50% 50%
Human Organ and Tissue Transplants[3] • Acquisition and transplant procedures, harvest and storage.	No copayment/coinsurance	50%
Prescription Drugs *Covered Thru ExpressScripts / RxOC Separate Out of Pocket Maximum $2500single/$5000family	Retail (30 Day Supply) Generic: $15 Preferred Brand: $30 Non-Preferred Brand: $50	Mail Order (90 Day Supply) Generic: $ 30 Preferred Brand: $ 60 Non-Preferred Brand: $100

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 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.
[4]Blue Distinction Total Care+ (BDC+) facilities can be found on www.anthem.com, provider directory under Hospitals. Network benefits will be paid at a higher level when knee/hip replacements, cardiac PCI and CBG surgeries and spine surgeries including discectomy, fusion and decompression procedures are performed at these facilities.
[5]Benefits may be denied for certain avoidable Emergency Room visits. See your certificate of benefits for details.

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.
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.

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Your Anthem Benefits

CEBCO Williams County Plan 2bb – GOLD PLAN
Blue Access℠ (PPO)
Summary of Benefits

Effective 01/01/2018

Covered Benefits	Network	Non-Network
Deductible (Single/Family)	$500/$1,000	$1,000/$2,000
Out-of-Pocket Limit (Single/Family)	$2,000/$4,000	$4,000/$8,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/Specialty Care Physician (SCP) Including Office Surgeries and allergy serum:	$20/$40	40%
• allergy injections (PCP and SCP)	$5	40%
• allergy testing	20%	40%
• routine and non-routine mammograms (regardless of outpatient setting)	No copayment/coinsurance	40%
• diabetic education (regardless of outpatient setting)	No copayment/coinsurance	40%
• 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	20%	40%
• LiveHealth Online (Telehealth) Medical visits	$0	Not Covered
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	40%
• Other Outpatient Services @ Hospital/Alternative Care Facility	No copayment/coinsurance	40%
Emergency (ER)[5] 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	20%	40%
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	20%	40%
• For certain surgeries, facilities with BDC+ distinction (knee/hip replacement, cardiac and spine)[4]	10%	Not applicable
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	20%	40%
Other Outpatient Services *(including but not limited to)*:		
• Non Surgical Outpatient Services for example: MRIs, C-Scans, Chemotherapy, Ultrasounds, and other diagnostic outpatient services.	20%	40%
• Home Care Services (Network/Non-network combined) 90 visits (excludes IV Therapy)	20%	40%
• Durable Medical Equipment, Orthotics and Prosthetic Devices	20%	40%
• Physical Medicine Therapy Day Rehabilitation programs	20%	40%
• Hospice Care	20%	20%
• Ambulance Services	20%	20%

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Behavioral Health Services: **Mental Health and Substance Abuse[2]** • Inpatient Facility Services • Inpatient Professional Services • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility ***These benefits have been tested and are compliant with Federal Mental Health Parity legislation.***	 20% 20% $20 20%	 40% 40% 40% 40%
Human Organ and Tissue Transplants[3] • Acquisition and transplant procedures, harvest and storage.	No copayment/coinsurance	50%
Prescription Drugs • **Through ESI/RxOC** **Separate Out of Pocket Maximum $2,500 Single/$5,000 Family**	Retail (30 Day Supply) Generic: $15 Preferred Brand: $30 Non-Preferred Brand: $50	Mail Order (90 Day Supply) Generic: $ 30 Preferred Brand: $ 60 Non-Preferred Brand: $100

Notes:

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