Your summary of benefits

Trumbull County Schools Insurance Benefits Consortium

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access PPO - $450

Your Network: Blue Access

Effective: January 1, 2023

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$450 person / $900 family	$900 person / $1,800 family
Out-of-Pocket Limit	$2,500 person / $5,000 family	$5,000 person / $10,000 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	35% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit	$20 copay per visit deductible does not apply	35% coinsurance after deductible is met
Specialist Care Visit	$20 copay per visit deductible does not apply	35% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	$20 copay per visit deductible does not apply	35% coinsurance after deductible is met
Preferred On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	$20 copay per visit deductible does not apply	35% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Other Participating Provider On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	$20 copay per visit deductible does not apply	35% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 60 visits per benefit period.* *Limit combined with Physical Therapy*	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Other Services in an Office:		
Allergy Testing	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Chemo/Radiation Therapy - Performed by a Primary Care Physician	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Chemo/Radiation Therapy – Performed by a Specialist	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Dialysis/Hemodialysis	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Prescription Drugs - *Dispensed in the office*	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Diagnostic Services **Lab:**		
Office	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Outpatient Hospital	15% coinsurance after deductible is met	35% coinsurance after deductible is met
X-Ray:		
Office	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Outpatient Hospital	15% coinsurance after deductible is met	35% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Advanced Diagnostic Imaging:		
Office	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Outpatient Hospital	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	$20 copay per visit deductible does not apply	35% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$250 copay per visit and 15% coinsurance deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	15% coinsurance after deductible is met	Covered as In-Network
Ambulance	15% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	$20 copay per visit deductible does not apply	35% coinsurance after deductible is met
Facility Visit:		
Facility Fees	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Doctor Services	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	15% coinsurance after deductible is met	35% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Doctor and Other Services: Hospital	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):		
Facility Fees *Coverage for Inpatient Rehabilitation Facility) and Skilled Nursing is limited to 180 days combined per benefit period.*	15% coinsurance after deductible is met	35% 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.*	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Doctor and other services	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care & Private Duty Nursing *Coverage is limited to 180 visits per benefit period. Limits are combined for all home health services.*	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Rehabilitation services:		
Office *Coverage for Occupational Therapy is limited to 25 visits per benefit period, Physical Therapy is limited to 60 visits per benefit period and Speech Therapy is limited to 25 visits per benefit period. Limit is combined for rehabilitative and habilitative services.*	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Outpatient Hospital *Coverage for Occupational Therapy is limited to 25 visits per benefit period, Physical Therapy is limited to 60 visits per benefit period and Speech Therapy is limited to 25 visits per benefit period. Limit is combined for rehabilitative and habilitative services.*	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Cardiac rehabilitation		
Office	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Outpatient Hospital	15% coinsurance after deductible is met	35% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Skilled Nursing Care (facility) *Coverage for Skilled Nursing and Inpatient Rehabilitation facility is limited to 180 days combined per benefit period.*	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Hospice	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Durable Medical Equipment	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Prosthetic Devices	15% coinsurance after deductible is met	35% coinsurance after deductible is met

Prescription Drug Benefits Carved Out

Notes:

- Dependent age: to end of the month in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- All medical deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).
- 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 a Non-network provider, the member is responsible for any balance due after the plan payment.
- If your plan includes out-of-network benefits, In-network and out-of-network deductibles, copayments, coinsurance and out-of-pocket maximum amounts are not separate and do not accumulate toward each other.
- ‡ Your cost share may be reduced when services are provided in a PCP's office.
- If you have receive Urgent Care at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services" which is generally coinsurance or coinsurance after your deductible is met.
- Benefit Period: Calendar Year

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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provider?	331-1067 for a list of network providers.	receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an Out-of-Network Provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20/visit deductible does not apply	40% coinsurance	--------none--------
	Specialist visit	$20/visit deductible does not apply	40% coinsurance	--------none--------
	Preventive care/screening/ immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	--------none--------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	--------none--------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.cvshealth.com	Tier 1 - Typically Generic	$5 retail and $10 home delivery	Not covered (retail and home delivery)	Prescription Drug coverage is provided by CVS Health. Covers up to 30 day supply retail and 90 day supply home delivery.
	Tier 2 - Typically Preferred Brand & Non-Preferred Generic Drugs	$20 retail and $40 home delivery	Not covered (retail and home delivery)	
	Tier 3 - Typically Non-Preferred Brand and Generic drugs	$35 retail and $70 home delivery	Not covered (retail and home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	--------none--------
	Physician/surgeon fees	20% coinsurance	40% coinsurance	--------none--------

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/aso.