

# Your summary of benefits



## Trumbull County Schools Insurance Benefits Consortium

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access PPO HSA

Your Network: Blue Access

Effective: January 1, 2021

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b>	\$1,500 person / \$3,000 family	\$3,000 person / \$6,000 family
<b>Out-of-Pocket Limit</b>	\$3,000 person / \$6,000 family	\$6,000 person / \$12,000 family
<p>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.</p>		
<b>Preventive Care / Screening / Immunization</b>	No charge	40% coinsurance after deductible is met
<b><u>Doctor Home and Office Services</u></b>		
<b>Primary Care Visit</b>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Specialist Care Visit</b>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b><u>Other Practitioner Visits:</u></b>		
Retail Health Clinic	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Preferred On-line Visit <i>Includes Mental/Behavioral Health and Substance Abuse</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Other Participating Provider On-line Visit <i>Includes Mental/Behavioral Health and Substance Abuse</i>	20% coinsurance after deductible is met	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
Manipulation Therapy <i>Coverage is limited to 60 visits per benefit period.            Limit combined with Physical Therapy</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b><u>Other Services in an Office:</u></b> Allergy Testing  Chemo/Radiation Therapy - Performed by a Primary Care Physician  Chemo/Radiation Therapy – Performed by a Specialist  Dialysis/Hemodialysis  Prescription Drugs - <i>Dispensed in the office</i>	20% coinsurance after deductible is met  20% coinsurance after deductible is met  20% coinsurance after deductible is met  20% coinsurance after deductible is met  20% coinsurance after deductible is met	40% coinsurance after deductible is met  40% coinsurance after deductible is met  40% coinsurance after deductible is met  40% coinsurance after deductible is met  40% coinsurance after deductible is met
<b><u>Diagnostic Services</u></b> <b>Lab:</b> Office  Outpatient Hospital	20% coinsurance after deductible is met  20% coinsurance after deductible is met	40% coinsurance after deductible is met  40% coinsurance after deductible is met
<b>X-Ray:</b> Office  Outpatient Hospital	20% coinsurance after deductible is met  20% coinsurance after deductible is met	40% coinsurance after deductible is met  40% coinsurance after deductible is met
<b>Advanced Diagnostic Imaging:</b> Office	20% coinsurance after deductible is met	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
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b><u>Emergency and Urgent Care</u></b> Urgent Care	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Emergency Room Facility Services</b>  <b>Emergency Room Doctor and Other Services</b>	20% coinsurance after deductible is met  20% coinsurance after deductible is met	Covered as In-Network  Covered as In-Network
<b>Ambulance</b>	20% coinsurance after deductible is met	Covered as In-Network
<b><u>Outpatient Mental/Behavioral Health and Substance Abuse</u></b> <b>Doctor Office Visit</b>  <b>Facility Visit:</b> Facility Fees  Doctor Services	20% coinsurance after deductible is met  20% coinsurance after deductible is met  20% coinsurance after deductible is met	40% coinsurance after deductible is met  40% coinsurance after deductible is met  40% coinsurance after deductible is met
<b><u>Outpatient Surgery</u></b> <b>Facility Fees:</b> Hospital  <b>Doctor and Other Services:</b> Hospital	20% coinsurance after deductible is met  20% coinsurance after deductible is met	40% coinsurance after deductible is met  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
<p><b><u>Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):</u></b></p> <p><b>Facility Fees</b>  <i>Coverage for Inpatient Rehabilitation Facility) and Skilled Nursing is limited to 180 days combined per benefit period.</i></p> <p><b>Human Organ and Tissue Transplants</b>  <i>Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.</i></p> <p><b>Doctor and other services</b></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b><u>Recovery &amp; Rehabilitation</u></b></p> <p><b>Home Health Care &amp; Private Duty Nursing</b>  <i>Coverage is limited to 180 visits per benefit period. Limits are combined for all home health services.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>
<p><b>Rehabilitation services:</b></p> <p><b>Office</b>  <i>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.</i></p> <p><b>Outpatient Hospital</b>  <i>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.</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b>Cardiac rehabilitation</b></p> <p><b>Office</b></p> <p><b>Outpatient Hospital</b></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b>Skilled Nursing Care (facility)</b>  <i>Coverage for Skilled Nursing and Inpatient Rehabilitation facility is limited to 180 days combined per benefit period.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Hospice</b>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Durable Medical Equipment</b>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Prosthetic Devices</b>	20% coinsurance after deductible is met	40% 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 separate and do accumulate toward each other.
- 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.*

## Get help in your language

Curious to know what all this says? We would be too. Here's the English version:

If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (833) 639-1634

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

(TTY/TDD: 711)

**Arabic (العربية):** إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (833) 639-1634.

**Armenian (հայերեն):** Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (833) 639-1634:

**Chinese(中文):** 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(833) 639-1634。

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**French (Français):** Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (833) 639-1634.

**Haitian Creole (Kreyòl Ayisyen):** Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (833) 639-1634.

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## Language Access Services:

**Navajo (Diné):** Dii naaltsoos biká'ígíí lahgo bina'idiikidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj bee níl hodoonih t'áadoo bąąh ilinígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínizingo koꞩ' hodiilnih (833) 639-1634.

**Polish (polski):** W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: (833) 639-1634.

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**Russian (Русский):** если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (833) 639-1634.

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