Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Plan: Mayfield City Schools: Anthem Blue Access PPO

Your Network: Blue Access

Effective: 7/1/2022

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$400 person / $800 family	$1,000 person / $2,000 family
Out-of-Pocket Limit	$400 person / $800 family	Unlimited person / Unlimited family
The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per person 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 per person deductible or per person out-of-pocket maximum. All medical deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services). Rx has a separate out-of-pocket maximum. In-network and out-of-network deductibles accumulate toward each other In-network and out-of-network out-of-pocket maximum amounts are separate and do not accumulate toward each other.		
Preventive Care / Screening / Immunization	No charge	20% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	20% coinsurance after medical deductible is met
Virtual Care (Telemedicine / Telehealth Visits) **Virtual Visits - Online visits with Doctors who also provide services in person**		
Primary Care (PCP)	$15 copay per visit medical deductible does not apply	20% coinsurance after medical deductible is met
Mental Health and Substance Abuse care	$15 copay per visit medical deductible does not apply	20% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Specialist	$15 copay per visit medical deductible does not apply	20% coinsurance after medical deductible is met
Medical Chats and Virtual (Video) Visits for Primary Care from our Online Provider K Health, through its affiliated Provider groups	No charge	
Virtual Visits from Online Provider LiveHealth Online *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*		
Primary Care (PCP) and Mental Health and Substance Abuse	$5 copay per visit medical deductible does not apply	
Specialist Care	$15 copay per visit medical deductible does not apply	
Visits in an Office		
Primary Care (PCP)	$15 copay per visit medical deductible does not apply	20% coinsurance after medical deductible is met
Specialist Care	$15 copay per visit medical deductible does not apply	20% coinsurance after medical deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Retail Health Clinic	$15 copay per visit medical deductible does not apply	20% coinsurance after medical deductible is met
Manipulation Therapy *Coverage is limited to 24 visits per benefit period.*	$15 copay per visit medical deductible does not apply	20% coinsurance after medical deductible is met
Other Services in an Office		
Allergy Testing *When Allergy injections are billed separately by network providers, the member is responsible for No cost share. When billed as part of an office visit, there is no additional cost to the member for the injection.*	No Charge	20% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Chemo/Radiation Therapy	No charge	20% coinsurance after medical deductible is met
Dialysis/Hemodialysis	$15 copay per visit medical deductible does not apply	20% coinsurance after medical deductible is met
Prescription Drugs *Dispensed in the office*	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Surgery	$15 copay per visit medical deductible does not apply	20% coinsurance after medical deductible is met
Diagnostic Services **Lab**		
Office	No charge	20% coinsurance after medical deductible is met
Outpatient Hospital	No charge	20% coinsurance after medical deductible is met
X-Ray		
Office	No charge	20% coinsurance after medical deductible is met
Outpatient Hospital	No charge	20% coinsurance after medical deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Outpatient Hospital	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency and Urgent Care		
Urgent Care	$20 copay per visit medical deductible does not apply	$20 copay per visit medical deductible does not apply
Emergency Room Facility Services *Copay waived if admitted.*	$125 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	0% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse		
Doctor Office Visit	$15 copay per visit medical deductible does not apply	20% coinsurance after medical deductible is met
Facility Visit		
Facility Fees	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Doctor Services	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Doctor and Other Services		
Hospital	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	0% coinsurance after medical deductible is met	20% coinsurance after medical 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.*	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Doctor and other services	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 60 visits per benefit period. Limits are combined for all home health services.*	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Rehabilitation services *Coverage for Occupational Therapy is limited to 50 visits per benefit period, Physical Therapy is limited to 50 visits per benefit period and Speech Therapy is limited to 50 visits per benefit period.* *Limit is combined for rehabilitative and habilitative services.*		
Office	$15 copay per visit medical deductible does not apply	20% coinsurance after medical deductible is met
Outpatient Hospital	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Cardiac rehabilitation *Coverage is limited to 50 visits per benefit period.*		
Office	$15 copay per visit medical deductible does not apply	20% coinsurance after medical deductible is met
Outpatient Hospital	$15 copay per visit medical deductible does not apply	20% coinsurance after medical deductible is met
Pulmonary rehabilitation *Coverage is limited to 50 visits per benefit period.*		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Office	$15 copay per visit medical deductible does not apply	20% coinsurance after medical deductible is met
Outpatient Hospital	$15 copay per visit medical deductible does not apply	20% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Coverage for Skilled Nursing is limited to 60 days per benefit period.* *Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 60 days per benefit period.*	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Inpatient Hospice	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Durable Medical Equipment	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit	**Separate Rx out-of-pocket limit:** $5,600 Single $11,200 Family	Not applicable
Prescription Drug Coverage *Cost shares for drugs included on the National Direct drug list appear below. Your plan uses the Base Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.*		

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Home Delivery Pharmacy *Maintenance medication are available through IngenioRx 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.*		
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$5 copay per prescription, deductible does not apply (retail) and $5 copay per prescription, deductible does not apply (home delivery)	Not Covered
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$10 copay per prescription, deductible does not apply (retail) and $10 copay per prescription, deductible does not apply (home delivery)	Not Covered
Tier 3 - Typically Non-Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$20 copay per prescription, deductible does not apply (retail) and $20 copay per prescription, deductible does not apply (home delivery)	Not Covered

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.		
Children's Vision (up to age 19) **Child Vision Deductible**	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Adult Vision (age 19 and older) **Adult Vision Deductible**	$0 person	$0 person
Vision exam	No charge	Reimbursed Up to $42

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Limited to 1 exam per benefit period.		

Notes:

- Benefit Period: Calendar Year
- 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.
- 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.
- The Primary Care Physician and Specialist office visit copay applies to both office and facility based office visits for evaluation and management services only.
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- If you have received 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.
- Ohio's House Bill 388 and the Federal No Surprises Act establish patient protections including from Out-of-Network Providers' surprise bills ("balance billing") for Emergency Care and other specified items or services. We will comply with these new state and federal requirements including how we process claims from certain Out-of-Network Providers.

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.

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.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date

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)

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Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'idiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih ninízingo kojį' hodíilnih (833) 639-1634.

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