

**CEBCO Delaware County – Plan 250B**  
**Blue Access<sup>SM</sup> (PPO)**  
**Summary of Benefits**

**Effective 01/01/2019**

Covered Benefits	Network	Non-Network
<b>Deductible (Single/Family)</b>	\$250/\$500	\$500/\$1,000
<b>Out-of-Pocket Limit (Single/Family)</b>	\$1,500/\$3,000	\$3,000/\$6,000
<b>Physician Home and Office Services (PCP/SCP)</b> Primary Care Physician (PCP)/Specialty Care Physician (SCP) Including Office Surgeries and allergy serum:	\$15/\$25	30%
<ul style="list-style-type: none"> <li>allergy injections (PCP and SCP)</li> </ul>	\$5	30%
<ul style="list-style-type: none"> <li>allergy testing</li> </ul>	10%	30%
<ul style="list-style-type: none"> <li>routine and non-routine mammograms (regardless of outpatient setting)</li> </ul>	No copayment/coinsurance	30%
<ul style="list-style-type: none"> <li>diabetic education (regardless of outpatient setting)</li> </ul>	No copayment/coinsurance	30%
<ul style="list-style-type: none"> <li>certain medical nutritional therapy (regardless of outpatient setting)</li> </ul>	No copayment/coinsurance	Not Covered
<ul style="list-style-type: none"> <li>MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies and non-maternity related Ultrasounds</li> </ul>	10%	30%
<ul style="list-style-type: none"> <li>LiveHealth Online (Telehealth) Medical visits</li> </ul>	No copayment/coinsurance	Not Covered
<b>Preventive Care Services</b> Services include but are not limited to: Routine Exams, Pelvic Exams, Pap testing, PSA tests, Immunizations <sup>1</sup> , Annual diabetic eye exam, Routine Vision and Hearing exams		
<ul style="list-style-type: none"> <li>Physician Home and Office Visits (PCP/SCP)</li> </ul>	No copayment/coinsurance	30%
<ul style="list-style-type: none"> <li>Other Outpatient Services @ Hospital/Alternative Care Facility</li> </ul>	No copayment/coinsurance	30%
<b>Emergency (ER)<sup>5</sup> and Urgent Care</b>		
<ul style="list-style-type: none"> <li>Emergency Room Services @ Hospital (facility/other covered services) (copayment waived if admitted)</li> </ul>	\$150	\$150
<ul style="list-style-type: none"> <li>Urgent Care Center Services</li> </ul>	\$35	\$35
<b>Inpatient and Outpatient Professional Services</b> Include but are not limited to:	10%	30%
<ul style="list-style-type: none"> <li>Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams</li> </ul>		
<ul style="list-style-type: none"> <li>For certain surgeries, facilities with BDC+ distinction; includes professional services (knee/hip replacement, cardiac and spine)<sup>4</sup></li> </ul>	No copayment/coinsurance	Not applicable
<b>Inpatient Facility Services</b> Unlimited days except for:	10%	30%
<ul style="list-style-type: none"> <li>60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)</li> </ul>		
<ul style="list-style-type: none"> <li>90 days Network/Non-Network combined for skilled nursing facility</li> </ul>		
<ul style="list-style-type: none"> <li>For certain surgeries, facilities with BDC+ distinction; includes professional services (knee/hip replacement, cardiac and spine)<sup>4</sup></li> </ul>	No copayment/coinsurance	Not applicable
<b>Outpatient Surgery Hospital/Alternative Care Facility</b>	10%	30%
<ul style="list-style-type: none"> <li>Surgery and administration of general anesthesia</li> </ul>		
<b>Other Outpatient Services (including but not limited to):</b>		
<ul style="list-style-type: none"> <li>Non Surgical Outpatient Services for example: MRIs, C-Scans, Chemotherapy, Ultrasounds, and other diagnostic outpatient services.</li> </ul>	10%	30%
<ul style="list-style-type: none"> <li>Home Care Services (Network/Non-network combined) 90 visits (excludes IV Therapy)</li> </ul>	10%	30%
<ul style="list-style-type: none"> <li>Durable Medical Equipment, Orthotics and Prosthetic Devices</li> </ul>	10%	30%
<ul style="list-style-type: none"> <li>Physical Medicine Therapy Day Rehabilitation programs</li> </ul>	10%	30%
<ul style="list-style-type: none"> <li>Hospice Care</li> </ul>	10%	10%
<ul style="list-style-type: none"> <li>Ambulance Services</li> </ul>	10%	10%

Covered Benefits	Network	Non-Network
<b>Outpatient Therapy Services</b> (Combined Network & Non-Network limits apply) <ul style="list-style-type: none"> <li>Physician Home and Office Visits (PCP/SCP)</li> <li>Other Outpatient Services @ Hospital/Alternative Care Facility</li> </ul> Limits apply to: Physical Medicine Therapy Limits, Outpatient Therapy (Network and Non-Network combined): <ul style="list-style-type: none"> <li>Physical therapy: 30 visits</li> <li>Occupational therapy: 30 visits</li> <li>Manipulation therapy: 12 visits</li> <li>Speech therapy: 20 visits</li> </ul>	\$15/\$25 10%	30% 30%
<b>Behavioral Health Services:</b> <b>Mental Health and Substance Abuse<sup>2</sup></b> <ul style="list-style-type: none"> <li>Inpatient Facility Services</li> <li>Inpatient Professional Services</li> <li>Physician Home and Office Visits (PCP/SCP)</li> <li>Other Outpatient Services @ Hospital/Alternative Care Facility</li> </ul> <p><i>These benefits have been tested and are compliant with Federal Mental Health Parity legislation.</i></p>	10% 10% \$15 10%	30% 30% 30% 30%
<b>Human Organ and Tissue Transplants<sup>3</sup></b> <ul style="list-style-type: none"> <li>Acquisition and transplant procedures, harvest and storage.</li> </ul>	No copayment/coinsurance	50%
<b>Prescription Drugs through RxOC/Express Scripts</b>	Covered under separate plan	Covered under separate plan

**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

<sup>1</sup>These covered services are not subject to the deductible/copayment if you have a flat dollar copayment and if rendered without an office visit.

<sup>2</sup>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.

<sup>3</sup>Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.

<sup>4</sup>Blue Distinction Total Care+ (BDC+) facilities can be found on [www.anthem.com](http://www.anthem.com), provider directory under Hospitals. Network benefits, facility and professional, 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.

<sup>5</sup>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.