

# Your summary of benefits



Anthem® Blue Cross and Blue Shield

**Centric Consulting LLC**

Your Plan: Anthem Blue Access PPO HSA

Your Network: Blue Access

**Effective: 1/1/2026**

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
<b>Primary Care, and medical services for urgent/acute care</b>	No charge after deductible is met
<b>Mental Health &amp; Substance Use Disorder Services</b>	No charge after deductible is met
<b>Specialist care</b>	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<b>Overall Deductible</b>	\$4,500 person / \$9,000 family	\$4,500 person / \$9,000 family
<b>Overall Out-of-Pocket Limit</b>	\$6,000 person / \$12,000 family	\$9,000 person / \$18,000 family
<p>The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit.</p> <p>All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit (excluding Out-of-Network Human Organ and Tissue Transplant (HOTT), Cellular and Gene Therapy services).</p> <p>In-Network and Out-of-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.</p>		
<b>Doctor Visits (virtual and office)</b> <i>You are encouraged to select a Primary Care Physician (PCP).</i>		
<b>Primary Care (PCP) and Mental Health and Substance Use Disorder Services</b> <i>virtual and office</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Specialist Provider</b> <i>virtual and office</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Other Practitioner Visits</b>		
<b>Maternity Doctor services</b> (prenatal/postpartum care and delivery)	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Retail Health Clinic</b> <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</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 an Out-of-Network Provider
<p><b><u>Other Services in an Office</u></b></p> <p><b>Allergy Testing</b></p> <p><b>Prescription Drugs</b> <i>Dispensed in the office</i></p> <p><b>Surgery</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>Preventive care / screenings / immunizations</b></p>	<p>No charge</p>	<p>40% coinsurance after deductible is met</p>
<p><b>Preventive Care for Chronic Conditions</b> <i>per IRS guidelines</i></p>	<p>No charge</p>	<p>Cost share is based on the setting services are received.</p>
<p><b><u>Diagnostic Services Lab</u></b></p> <p>Office</p> <p>Outpatient Hospital</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><u>Diagnostic Services X-Ray</u></b></p> <p>Office</p> <p>Outpatient Hospital</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><u>Diagnostic Services Advanced Diagnostic Imaging</u></b> <i>for example: MRI, PET and CAT scans</i></p> <p>Office</p> <p>Outpatient Hospital</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><u>Emergency and Urgent Care</u></b></p> <p><b>Urgent Care</b></p> <p><b>Emergency Room Facility Services</b></p> <p><b>Emergency Room Doctor and Other Services</b></p> <p><b>Ambulance</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>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p><b><u>Outpatient Mental Health and Substance Use Disorder Services at a Facility</u></b></p> <p><b>Facility Fees</b></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 an Out-of-Network Provider
<b>Doctor Services</b>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p><b><u>Outpatient Surgery</u></b></p> <p><b>Facility Fees</b> Hospital</p> <p><b>Physician and other services</b> <i>including surgeon fees</i> Hospital</p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p><b><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u></b></p> <p><b>Facility Fees</b></p> <p><b>Human Organ and Tissue Transplants</b> <i>Cornea transplants are treated as medical procedures, with benefits and cost sharing determined by the setting in which the services are received. You must get certain covered transplant procedures from an Approved In-Network Provider to receive the In-Network level of benefits.</i></p> <p><b>Physician and other services</b> <i>including surgeon fees</i></p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p><b><u>Home Health Care</u></b> <i>Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.</i></p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p><b><u>Therapy Services</u></b></p> <p><b>Rehabilitation and Habilitation services</b> <i>including physical, occupational and speech therapies.</i> <i>Coverage for physical, occupational, and speech therapies are a combined limit of 45 visits each per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p> <p><b>Manipulation Therapy</b> <i>office and outpatient hospital</i> <i>Coverage is limited to 24 visits per benefit period.</i></p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p><b>Pulmonary rehabilitation</b> <i>office and outpatient hospital</i> <i>Coverage is limited to 20 visits per benefit period.</i></p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p><b>Cardiac rehabilitation</b> <i>office and outpatient hospital</i> <i>Coverage is limited to 36 visits per benefit period.</i></p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p><b>Dialysis/Hemodialysis</b> <i>office and outpatient hospital</i></p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p><b>Chemo/Radiation Therapy</b> <i>office and outpatient hospital</i></p>	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 an Out-of-Network Provider
<b>Skilled Nursing Care (facility)</b> <i>Coverage for Skilled Nursing and Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 100 days combined per benefit period.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Inpatient Hospice</b>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b><u>Additional Services, Equipment and Devices</u></b> <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
<b>Wigs</b> <i>Coverage for wigs is limited to 1 item per benefit period.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Hearing Aids</b> Maximum \$4,000 per 36 months	20% coinsurance after deductible is met	Not Covered

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
<b>Pharmacy Deductible</b>	Combined with In-Network medical deductible	Combined with Out-of-Network medical deductible
<b>Pharmacy Out-of-Pocket Limit</b>	Combined with In-Network medical out-of-pocket limit	Combined with Out-of-Network medical out-of-pocket limit
<b>Prescription Drug Coverage</b> <b>Network: <i>Base Network</i></b> <b>Drug List: <i>National Direct Plus</i></b> <i>If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.</i>		
<b>Day Supply Limits:</b> <b>Retail Pharmacy</b> <i>30 day supply (cost shares noted below)</i> <b>Retail 90 Pharmacy</b> <i>90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).</i> <b>Home Delivery Pharmacy</b> <i>90 day supply (maximum cost shares noted below). Maintenance medications are available through our 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.</i> <b>Specialty Pharmacy</b> <i>30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.</i>		
<b>Preventive Drugs</b> <i>No deductible, copayment or coinsurance applies to prescription drugs on the PreventiveRX Plus drug list when you use an In-Network Pharmacy.</i>		
<b>Tier 1 - Typically Generic</b>	20% coinsurance after	40% coinsurance after

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
	deductible is met (retail and home delivery)	deductible is met (retail) and Not covered (home delivery)
<b>Tier 2 - Typically Preferred Brand</b>	20% coinsurance after deductible is met (retail and home delivery)	40% coinsurance after deductible is met (retail) and Not covered (home delivery)
<b>Tier 3 - Typically Non-Preferred Brand</b>	20% coinsurance after deductible is met (retail and home delivery)	40% coinsurance after deductible is met (retail) and Not covered (home delivery)
<b>Tier 4 - Typically Specialty (brand and generic)</b>	20% coinsurance after deductible is met (retail and home delivery)	40% coinsurance after deductible is met (retail) and Not covered (home delivery)

**Notes:**

- Dependent Age Limit: to the end of the month in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using Out-of-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 an Out-of-Network Provider, the member is responsible for any balance due after the plan payment.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under “Outpatient Facility Services”.
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
- 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.
- 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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Questions: (833) 639-1634 or visit us at [www.anthem.com](http://www.anthem.com)