

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Worthington City Schools

Your Plan: Anthem Blue Access PPO HSA \$2,200

Your Network: Blue Access

Effective Date: 1/1/2026

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge after deductible is met
Mental Health & Substance Use Disorder Services	No charge after deductible is met
Specialist care	15% 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
Overall Deductible	\$2,200 person / \$4,400 family	\$4,400 person / \$8,800 family
Overall Out-of-Pocket Limit	\$2,750 person / \$5,500 family	\$5,500 person / \$11,000 family
The family deductible and out-of-pocket limit are non-embedded, meaning the cost shares of all family members apply to one family deductible and one family out-of-pocket limit. The per person deductible and per person out-of-pocket limit apply to individuals enrolled under single-only coverage. 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). In-Network and Out-of-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.		
Doctor Visits (virtual and office) <i>You are encouraged to select a Primary Care Physician (PCP).</i>		
Primary Care (PCP) and Mental Health and Substance Use Disorder Services <i>virtual and office</i>	15% coinsurance after deductible is met	30% coinsurance after deductible is met
Specialist Provider <i>virtual and office</i>	15% coinsurance after deductible is met	30% coinsurance after deductible is met
Other Practitioner Visits		
Maternity Doctor services (prenatal/postpartum care and delivery)	15% coinsurance after deductible is met	30% coinsurance after deductible is met
Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i>	15% coinsurance after deductible is met	30% coinsurance after deductible is met
Other Services in an Office		
Allergy Testing	15% coinsurance after deductible is met	30% 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
Prescription Drugs <i>Dispensed in the office</i>	15% coinsurance after deductible is met	30% coinsurance after deductible is met
Surgery	15% coinsurance after deductible is met	30% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	30% coinsurance after deductible is met
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	Cost share is based on the setting services are received.
<u>Diagnostic Services Lab</u>		
Office	15% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	15% coinsurance after deductible is met	30% coinsurance after deductible is met
<u>Diagnostic Services X-Ray</u>		
Office	15% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	15% coinsurance after deductible is met	30% coinsurance after deductible is met
<u>Diagnostic Services Advanced Diagnostic Imaging</u> <i>for example: MRI, PET and CAT scans</i>		
Office	15% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	15% coinsurance after deductible is met	30% coinsurance after deductible is met
<u>Emergency and Urgent Care</u>		
Urgent Care	15% coinsurance after deductible is met	30% coinsurance after deductible is met
Emergency Room Facility Services	15% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	15% coinsurance after deductible is met	Covered as In-Network
Ambulance <i>Authorized Out-of-Network non-emergency ambulance services are limited to an Anthem maximum payment of \$50,000 per trip. The \$50,000 limit does not apply to air ambulance services.</i>	15% coinsurance after deductible is met	Covered as In-Network
<u>Outpatient Mental Health and Substance Use Disorder Services at a Facility</u>		
Facility Fees	15% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor Services	15% coinsurance after deductible is met	30% 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
<u>Outpatient Surgery</u> Facility Fees Hospital Physician and other services including surgeon fees Hospital	15% coinsurance after deductible is met 15% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met
<u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u> Facility Fees Human Organ and Tissue Transplants <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> Physician and other services including surgeon fees	15% coinsurance after deductible is met 15% coinsurance after deductible is met 15% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met
<u>Home Health Care</u> <i>Coverage is limited to 60 visits per benefit period. Private Duty Nursing is not covered. Limits are separate for all home health services.</i>	15% coinsurance after deductible is met	30% coinsurance after deductible is met
<u>Therapy Services</u> Rehabilitation and Habilitation services including physical, occupational and speech therapies. <i>Coverage for physical and occupational therapies is limited to 20 visits each per benefit period.</i> <i>Coverage for speech therapy is limited to 40 visits each per benefit period.</i> Office Outpatient Hospital Manipulation Therapy office and outpatient hospital <i>Coverage is limited to 50 visits per benefit period.</i>	15% coinsurance after deductible is met 15% coinsurance after deductible is met 15% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met
Pulmonary rehabilitation office and outpatient hospital <i>Coverage is limited to 20 visits per benefit period.</i>	15% coinsurance after deductible is met	30% coinsurance after deductible is met
Cardiac rehabilitation office and outpatient hospital <i>Coverage is limited to 36 visits per benefit period.</i>	15% coinsurance after deductible is met	30% coinsurance after deductible is met
Dialysis/Hemodialysis office and outpatient hospital	15% coinsurance after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy office and outpatient hospital	15% coinsurance after deductible is met	30% 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
Skilled Nursing Care (facility) <i>Coverage for Skilled Nursing is limited to 180 days per benefit period. Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is unlimited days combined per benefit period.</i>	15% coinsurance after deductible is met	30% coinsurance after deductible is met
Inpatient Hospice	15% coinsurance after deductible is met	30% coinsurance after deductible is met
<u>Additional Services, Equipment and Devices</u> Durable Medical Equipment	15% coinsurance after deductible is met	30% coinsurance after deductible is met
Prosthetic Devices <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	15% coinsurance after deductible is met	30% coinsurance after deductible is met
Hearing Aids (for members through age 21) <i>Coverage is limited to 1 item, up to \$2,500 per hearing-impaired ear, every 48 months.</i>	No charge after deductible is met	30% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with Out-of-Network medical deductible
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Out-of-Network medical out-of-pocket limit
Prescription Drug Coverage Network: Base Network Drug List: National Direct Plus <i>If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.</i>		
Day Supply Limits: Retail Pharmacy 31 day supply (cost shares noted below) Retail 90 Pharmacy 90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies). Home Delivery Pharmacy 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. Specialty Pharmacy 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.		
Preventive Drugs No deductible, copayment or coinsurance applies to prescription drugs on the PreventiveRX Enhanced drug list when you use an In-Network Pharmacy.		
Tier 1 - Typically Generic	15% coinsurance after deductible is met (retail and home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 - Typically Preferred Brand	15% coinsurance after deductible is met (retail and home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	15% coinsurance after deductible is met (retail and home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<i>This is a brief outline of your vision coverage. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out-of-pocket limit.</i>		
Children's Vision exam (up to age 19) <i>Limited to 1 exam per benefit period.</i>	No charge	\$0 copayment up to plan's Maximum Allowed Amount
Adult Vision exam (age 19 and older) <i>Limited to 1 exam per benefit period.</i>	No charge	Reimbursed Up to \$42

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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