Your summary of benefits

Anthem
Effective: January 1, 2026

Anthem® Blue Cross and Blue Shield

Your Plan: EPC Southwestern Ohio Educational Purchasing Cncl: Franklin City PPO

Your Network: BlueCard PPO

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	$20 copay per visit medical deductible does not apply
Mental Health & Substance Use Disorder Services	$20 copay per visit medical deductible does not apply
Specialist care	$20 copay per visit medical deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	$100 person / $300 family	$200 person / $400 family
Overall Out-of-Pocket Limit	$1,500 person / $3,000 family	$2,000 person / $4,000 family
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. All medical 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) *You are encouraged to select a Primary Care Physician (PCP).*		
Primary Care (PCP) and Mental Health and Substance Use Disorder Services *virtual and office*	$20 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Specialist Provider *virtual and office*	$20 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Other Practitioner Visits		
Maternity Doctor services (prenatal/postpartum care and delivery) *The first visit with In-Network provider to establish pregnancy diagnosis is $20 copay medical deductible does not apply*	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$20 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Other Services in an Office		
Allergy Testing	$20 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Prescription Drugs *Dispensed in the office*	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Surgery	$20 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Preventive care / screenings / immunizations	No charge	30% coinsurance after medical deductible is met
Diagnostic Services Lab		
Office	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Outpatient Hospital	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Diagnostic Services X-Ray		
Office	No charge	30% coinsurance after medical deductible is met
Outpatient Hospital	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Diagnostic Services Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Outpatient Hospital	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	$50 copay per visit medical deductible does not apply	$50 copay per visit medical deductible does not apply
Emergency Room Facility Services *Your copay will be waived if admitted.*	$100 copay per visit medical deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Ambulance	No charge	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Doctor Services	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Physician and other services *including surgeon fees*		
Hospital	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)		
Facility Fees	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Human Organ and Tissue Transplants *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.*	No charge	50% coinsurance after medical deductible is met
Physician and other services *including surgeon fees*	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Home Health Care *Coverage is limited to 30 visits per benefit period for Out-of-network Providers.*	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Therapy Services		
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for physical and occupational therapies is limited to 60 visits combined per benefit period. Coverage for speech therapy is limited to 50 visits per benefit period.*		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Office	$20 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Outpatient Hospital	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Manipulation Therapy *Coverage is limited to 12 visits per benefit period.*		
Office	$20 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Outpatient Hospital	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Pulmonary rehabilitation		
Office	$20 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Outpatient Hospital	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Cardiac rehabilitation		
Office	$20 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Outpatient Hospital	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Chemo/Radiation Therapy		
Office	$20 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Outpatient Hospital	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Coverage is limited to 180 days per benefit period.*	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Inpatient Hospice *Life expectancy up to 12 Months.*	10% coinsurance after medical deductible is met	10% coinsurance after medical deductible is met
Additional Services, Equipment and Devices **Durable Medical Equipment**	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Prosthetic Devices	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Wigs *Coverage for wigs is limited to 1 unit per benefit period subject to Medical Necessity.*	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Hearing Aids *Coverage is limited to 1 item per ear every 3 benefit periods.*	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Provider Pharmacy
Pharmacy Deductible	Not covered	Not covered
Pharmacy Out-of-Pocket Limit	Not covered	Not covered
Prescription Drug Coverage **Network:** **Drug List:**		
Day Supply Limits:		
Tier 1 - Typically Generic	Not covered	Not covered
Tier 2 – Typically Preferred Brand	Not covered	Not covered
Tier 3 - Typically Non-Preferred Brand	Not covered	Not covered

Tier 4 - Typically Specialty (brand and generic)	Not covered	Not covered

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
This is a brief outline of your vision coverage.		
Child Vision exam	No charge	30% coinsurance after medical deductible is met
Adult Vision exam	No charge	30% coinsurance after medical deductible is met

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.
- 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.
- 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.
- 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.

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Questions: (855) 255-9952 or visit us at www.anthem.com

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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

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document

Spanish
Usted tiene derecho a obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

Chinese
您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID 卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

Vietnamese
Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của tài liệu này.

Korean
귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인이신가요? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

Tagalog
May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

Russian
У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

French Creole
Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòma nan dokiman sa a.

Arabic
لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجانًا. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضًا طلب تنسيقات أخرى لهذه الوثيقة.

French
Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

Persian
شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

Armenian
Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Պարզապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցո՞ղ եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

Japanese
あなたにはあなたの言語で無料で支援を受ける権利があります。ID カードに記載されている会員サービス番号にお電話ください」視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

Italian
Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

German
Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen Formaten anfordern.

Polish
Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

Pennsylvania Dutch
Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kannscht des do Schreiwes in en differnter Weg griege so as du's besser sehne kannscht.

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Here's an overview of your CVS Caremark Benefits

Franklin City PPO – 1/1/2026

Visit **caremark.com** to access plan materials, price medications and locate pharmacies. If you have further questions about your prescription plan or costs, please call 1-888-202-1654. For TDD assistance, please call 1-800-863-5488.

	Short-Term Medicines CVS Caremark Retail Pharmacy Network (Up to a 30-day supply)	**Long-Term Medicines** CVS Caremark Mail Service Pharmacy or CVS Pharmacy Locations (Up to a 90-day supply)
Generic Medicines Always ask your doctor if there's a generic option available. It could save you money.	**$10** for a generic medicine	**$20** for a generic medicine
Preferred Brand-Name Medicines If a generic is not available or appropriate, ask your doctor to prescribe from your plan's preferred drug list.	**$20** for a preferred brand-name medicine	**$40** for a preferred brand-name medicine
Non-Preferred Brand-Name Medicines Drugs that aren't on your plan's preferred list will cost more.	**$30** for a non-preferred brand-name medicine	**$60** for a non-preferred brand-name medicine
Refill Limit	**None**	**None**
Maximum Out-of-Pocket	**$3,000 per individual / $6,000 per family**	
Specialty Medicines	**$30% coinsurance OR $0 copay with PrudentRx** Specialty medications are required to be filled through CVS Specialty Mail Order Pharmacy or at a retail CVS/pharmacy. Please contact Customer Care toll-free at 1-888-202-1654 for questions or to get started today.	
Prior Authorization	Certain medications may require prior authorization. Please contact Customer Care toll-free at 1-888-202-1654 or visit www.caremark.com for verification of prior authorization requirements.	

Copayment, copay or coinsurance means the amount a plan member is required to pay for a prescription in accordance with a Plan which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.
Your feedback is important as it helps us improve our service. Please contact us with any questions or concerns at 1-888-202-1654.
If you access your pharmacy benefits information through the Caremark Web site, you can find Plan Members Rights and Responsibilities at www.caremark.com.
Your privacy is important to us. Our employees are trained regarding the appropriate way to handle private health information