

# Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Plan: Epc Southwestern Ohio Educational Purchasing Cncl: Eaton Low (\$2600 Deductible) PPO

Your Network: BlueCard PPO

| Visits with Virtual Care-Only Providers                         | Cost through our mobile app and website |
|-----------------------------------------------------------------|-----------------------------------------|
| <b>Primary Care, and medical services for urgent/acute care</b> | 10% coinsurance after deductible is met |
| <b>Mental Health &amp; Substance Use Disorder Services</b>      | 10% coinsurance after deductible is met |
| <b>Specialist care</b>                                          | 10% 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>          | \$2,600 person /<br>\$5,200 family     | \$5,200 person /<br>\$10,400 family        |
| <b>Overall Out-of-Pocket Limit</b> | \$5,200 person /<br>\$10,400 family    | \$10,400 person /<br>\$20,800 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).*

|                                                                                                                                            |                                         |                                         |
|--------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|-----------------------------------------|
| <b>Primary Care (PCP) and Mental Health and Substance Use Disorder Services</b> <i>virtual and office</i>                                  | 10% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| <b>Specialist Provider</b> <i>virtual and office</i>                                                                                       | 10% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| <b><u>Other Practitioner Visits</u></b>                                                                                                    |                                         |                                         |
| <b>Maternity Doctor services</b> (prenatal/postpartum care and delivery)                                                                   | 10% 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> | 10% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| <b><u>Other Services in an Office</u></b>                                                                                                  |                                         |                                         |
| <b>Allergy Testing</b>                                                                                                                     | No charge                               | 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>Prescription Drugs</b> <i>Dispensed in the office</i>                                                                                                                                                                                                                                  | 10% coinsurance after deductible is met                                                                                               | 40% coinsurance after deductible is met                                                                                        |
| <b>Surgery</b>                                                                                                                                                                                                                                                                            | 10% coinsurance after deductible is met                                                                                               | 40% coinsurance after deductible is met                                                                                        |
| <b>Preventive care / screenings / immunizations</b>                                                                                                                                                                                                                                       | No charge                                                                                                                             | 40% coinsurance after deductible is met                                                                                        |
| <b><u>Diagnostic Services Lab</u></b><br>Office<br><br>Outpatient Hospital                                                                                                                                                                                                                | 10% coinsurance after deductible is met<br><br>10% coinsurance after deductible is met                                                | 40% coinsurance after deductible is met<br><br>40% coinsurance after deductible is met                                         |
| <b><u>Diagnostic Services X-Ray</u></b><br>Office<br><br>Outpatient Hospital                                                                                                                                                                                                              | 10% coinsurance after deductible is met<br><br>10% coinsurance after deductible is met                                                | 40% coinsurance after deductible is met<br><br>40% coinsurance after deductible is met                                         |
| <b><u>Diagnostic Services Advanced Diagnostic Imaging</u></b> <i>for example: MRI, PET and CAT scans</i><br>Office<br><br>Outpatient Hospital                                                                                                                                             | 10% coinsurance after deductible is met<br><br>10% coinsurance after deductible is met                                                | 40% coinsurance after deductible is met<br><br>40% coinsurance after deductible is met                                         |
| <b><u>Emergency and Urgent Care</u></b><br><b>Urgent Care</b> <i>includes doctor services. Additional charges may apply depending on the care provided.</i><br><br><b>Emergency Room Facility Services</b><br><br><b>Emergency Room Doctor and Other Services</b><br><br><b>Ambulance</b> | 10% coinsurance after deductible is met<br><br>10% coinsurance after deductible is met<br><br>10% coinsurance after deductible is met | 40% coinsurance after deductible is met<br><br>Covered as In-Network<br><br>Covered as In-Network<br><br>Covered as In-Network |
| <b><u>Outpatient Mental Health and Substance Use Disorder Services at a Facility</u></b><br><b>Facility Fees</b><br><br><b>Doctor Services</b>                                                                                                                                            | 10% coinsurance after deductible is met<br><br>10% coinsurance after deductible is met                                                | 40% coinsurance after deductible is met<br><br>40% coinsurance after deductible is met                                         |
| <b><u>Outpatient Surgery</u></b><br><b>Facility Fees</b><br>Hospital                                                                                                                                                                                                                      | 10% 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>Physician and other services</b> <i>including surgeon fees</i><br>Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 10% coinsurance after deductible is met                                                                                                           | 40% coinsurance after deductible is met                                                                                                           |
| <b><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u></b><br><br><b>Facility Fees</b><br><br><b>Human Organ and Tissue Transplants</b><br><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><br><br><b>Physician and other services</b> <i>including surgeon fees</i> | 10% coinsurance after deductible is met<br><br>No charge<br><br>10% coinsurance after deductible is met                                           | 40% coinsurance after deductible is met<br><br>50% coinsurance after deductible is met<br><br>40% coinsurance after deductible is met             |
| <b><u>Home Health Care</u></b><br><i>Coverage is limited to 30 visits per benefit period for Out-of-Network Providers.</i>                                                                                                                                                                                                                                                                                                                                                                                                                              | No charge                                                                                                                                         | 40% coinsurance after deductible is met                                                                                                           |
| <b><u>Therapy Services</u></b><br><b>Rehabilitation and Habilitation services</b> <i>including physical, occupational and speech therapies.</i><br><i>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.</i><br><br>Office<br><br>Outpatient Hospital<br><br><b>Manipulation Therapy</b> <i>office and outpatient hospital</i><br><i>Coverage is limited to 12 visits per benefit period.</i>                                | <br><br><br><br><br>10% coinsurance after deductible is met<br>10% coinsurance after deductible is met<br>10% coinsurance after deductible is met | <br><br><br><br><br>40% coinsurance after deductible is met<br>40% coinsurance after deductible is met<br>40% coinsurance after deductible is met |
| <b>Pulmonary rehabilitation</b> <i>office and outpatient hospital</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 10% coinsurance after deductible is met                                                                                                           | 40% coinsurance after deductible is met                                                                                                           |
| <b>Cardiac rehabilitation</b> <i>office and outpatient hospital</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 10% coinsurance after deductible is met                                                                                                           | 40% coinsurance after deductible is met                                                                                                           |
| <b>Dialysis/Hemodialysis</b> <i>office and outpatient hospital</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 10% coinsurance after deductible is met                                                                                                           | 40% coinsurance after deductible is met                                                                                                           |
| <b>Chemo/Radiation Therapy</b> <i>office and outpatient hospital</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 10% coinsurance after deductible is met                                                                                                           | 40% coinsurance after deductible is met                                                                                                           |
| <b>Skilled Nursing Care (facility)</b><br><i>Coverage is limited to 180 days per benefit period.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 10% coinsurance after deductible is met                                                                                                           | 40% coinsurance after deductible is met                                                                                                           |
| <b>Inpatient Hospice</b><br><i>Life expectancy up to 12 months.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | No charge                                                                                                                                         | No charge                                                                                                                                         |
| <b><u>Additional Services, Equipment and Devices</u></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                   |                                                                                                                                                   |

| Covered Medical Benefits                                                                                      | Cost if you use an In-Network Provider  | Cost if you use an Out-of-Network Provider |
|---------------------------------------------------------------------------------------------------------------|-----------------------------------------|--------------------------------------------|
| <b>Durable Medical Equipment</b>                                                                              | 10% coinsurance after deductible is met | 40% coinsurance after deductible is met    |
| <b>Prosthetic Devices</b>                                                                                     | 10% coinsurance after deductible is met | 40% coinsurance after deductible is met    |
| <b>Wigs</b><br><i>Coverage for wigs is limited to 1 unit per benefit period subject to Medical Necessity.</i> | 10% coinsurance after deductible is met | 40% coinsurance after deductible is met    |
| <b>Hearing Aids</b><br><i>Coverage is limited to 1 item per ear every 3 benefit periods.</i>                  | 10% coinsurance after deductible is met | 40% 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 |
| <b>Pharmacy Deductible</b>                                                                                    | Not covered                             | Not covered                                |
| <b>Pharmacy Out-of-Pocket Limit</b>                                                                           | Not covered                             | Not covered                                |
| <b>Prescription Drug Coverage</b><br><b>Network:</b><br><b>Drug List:</b>                                     |                                         |                                            |
| <b>Day Supply Limits:</b>                                                                                     |                                         |                                            |
| <b>Tier 1 - Typically Generic</b>                                                                             | Not covered (retail and home delivery)  | Not covered (retail and home delivery)     |
| <b>Tier 2 – Typically Preferred Brand</b>                                                                     | Not covered (retail and home delivery)  | Not covered (retail and home delivery)     |
| <b>Tier 3 - Typically Non-Preferred Brand</b>                                                                 | Not covered (retail and home delivery)  | Not covered (retail and home delivery)     |
| <b>Tier 4 - Typically Specialty (brand and generic)</b>                                                       | Not covered (retail and home delivery)  | Not covered (retail and 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.</i> |                                        |                                            |
| <b>Child Vision exam</b>                                | No charge                              | 40% coinsurance after deductible is met    |
| <b>Adult Vision exam</b>                                | No charge                              | 40% coinsurance after 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.
- 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](http://www.anthem.com)

# Your summary of benefits



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Your Network: BlueCard PPO

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 장애인인가요? 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 fòm nan dokiman sa a.

### Arabic

لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجاناً. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضاً 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: Դարգապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցող 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>