Your summary of benefits

Anthem

CEBCO

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access CEBCO Clermont County PPO HSA Plan

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	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
Overall Deductible	$3,400 person / $6,800 family	$6,800 person / $13,600 family
Overall Out-of-Pocket Limit	$4,000 person / $8,000 family	$8,000 person / $16,000 family
EMBEDDED: 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*	10% after deductible is met	30% coinsurance after deductible is met
Specialist Provider *virtual and office*	10% after deductible is met	30% coinsurance after deductible is met
Other Practitioner Visits		
Maternity Doctor services (prenatal/postpartum care and delivery)	10% after deductible is met	30% coinsurance after deductible is met
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	10% after deductible is met	30% coinsurance after deductible is met
Other Services in an Office		
Allergy Testing	10% after deductible is met	30% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	10% 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
Surgery	10% after deductible is met	30% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	30% coinsurance after deductible is met
Diagnostic Services Lab		
Office	10% after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	10% after deductible is met	30% coinsurance after deductible is met
Diagnostic Services X-Ray		
Office	10% after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	10% after deductible is met	30% coinsurance after deductible is met
Diagnostic Services Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	10% after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	10% after deductible is met	30% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	10% after deductible is met	30% coinsurance after deductible is met
Emergency Room Facility Services *Your copay will be waived if admitted.*	10% after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	10% after deductible is met	Covered as In-Network
Ambulance	10% after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	10% after deductible is met	30% coinsurance after deductible is met
Doctor Services	10% after deductible is met	30% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	10% 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
Physician and other services *including surgeon fees* Hospital	10% after deductible is met	30% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services) **Facility Fees**	10% after deductible is met	30% coinsurance after 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.*	10% after deductible is met	30% coinsurance after deductible is met
Physician and other services *including surgeon fees*	10% after deductible is met	30% coinsurance after deductible is met
Home Health Care *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	10% after deductible is met	30% coinsurance after deductible is met
Therapy Services **Rehabilitation and Habilitation services** *Coverage for physical and occupational therapies is limited to 30 visits each per benefit period and speech therapy is limited to 20 visits per benefit period.* Office	10% after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	10% after deductible is met	30% coinsurance after deductible is met
Manipulation Therapy *office and outpatient hospital* *Coverage is limited to 12 visits per benefit period.*	10% after deductible is met	30% coinsurance after deductible is met
Pulmonary rehabilitation *office and outpatient hospital* *Coverage is limited to 20 visits per benefit period.*	10% after deductible is met	30% coinsurance after deductible is met
Cardiac rehabilitation *office and outpatient hospital* *Coverage is limited to 36 visits per benefit period.*	10% after deductible is met	30% coinsurance after deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	10% after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy *office and outpatient hospital*	10% after deductible is met	30% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage for Skilled Nursing and Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 90 days combined per benefit period.*	10% after deductible is met	30% coinsurance after deductible is met
Inpatient Hospice	10% 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
Additional Services, Equipment and Devices **Durable Medical Equipment**	10% after deductible is met	30% coinsurance after deductible is met
Prosthetic Devices	10% after deductible is met	30% coinsurance after deductible is met
Wigs *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	10% after deductible is met	30% coinsurance after deductible is met
Hearing Aids *Coverage is limited to 1 hearing aid per hearing impaired ear every 48 months, for members through age 21, including wearable and bone anchored hearing aids with a dollar maximum of $2,500 per ear.*	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 out-of-pocket limit
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*** *Drugs not included on the drug list will not be covered.*		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **RX Maintenance 90 Pharmacy** *90 day supply (after 2 courtesy 30-day fills you will be required to purchase maintenance medications in 90-day fills at a RXM90 pharmacy or home delivery).* **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. Drug cost share assistance programs may be available for certain specialty drugs.*		
Preventive Drugs *The deductible does not apply to prescription drugs on the Preventive Rx Enhanced drug list when you use an In-Network pharmacy.*		
Tier 1 - Typically Generic	10% 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	10% 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 & Specialty	10% coinsurance after deductible is met (retail and home delivery)	30% coinsurance after deductible is met (retail) and not covered (home delivery & Specialty)

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.
- The representations of benefits in this document are subject to Ohio Department of Insurance (ODI) approval and are subject to change.

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) 603-7982 or visit us at www.anthem.com