

Your summary of benefits



CEBCO

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access CEBCO Clermont County PPO Premium 5G Copay Plan Rx 5G

Your Network: Blue Access

Effective Date 1/1/2027

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge medical deductible does not apply
Mental Health & Substance Use Disorder Services	No charge medical deductible does not apply
Specialist care	\$60 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	\$3,000 person / \$6,000 family	\$6,000 person / \$12,000 family
Overall Out-of-Pocket Limit	\$6,000 person / \$12,000 family	\$12,000 person / \$24,000 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 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) *You are encouraged to select a Primary Care Physician (PCP).*

Primary Care (PCP) <i>virtual and office</i>	\$30 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Mental Health and Substance Use Disorder Services <i>virtual and office</i>	\$30 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Specialist Provider <i>virtual and office</i>	\$60 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Other Practitioner Visits		
Maternity Doctor services (prenatal/postpartum care and delivery)	20% coinsurance after medical deductible is met	40% 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
Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i>	\$30 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
<u>Other Services in an Office</u>		
Allergy Testing	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Allergy Injections	\$5 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Prescription Drugs <i>Dispensed in the office</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Surgery	\$60 copay per visit medical deductible does not apply [†]	40% coinsurance after medical deductible is met
Preventive care / screenings / immunizations	No charge	40% coinsurance after medical deductible is met
<u>Diagnostic Services Lab</u>		
Office	No charge	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<u>Diagnostic Services X-Ray</u>		
Office	No charge	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<u>Diagnostic Services Advanced Diagnostic Imaging</u> <i>for example: MRI, PET and CAT scans</i>		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% 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
<u>Emergency and Urgent Care</u> Urgent Care <i>includes doctor services. Additional charges may apply depending on the care provided.</i> Emergency Room Facility Services <i>Your copay will be waived if admitted.</i> Emergency Room Doctor and Other Services Ambulance	\$75 copay per visit medical deductible does not apply \$300 copay per visit and 0% coinsurance medical deductible does not apply 0% coinsurance medical deductible does not apply 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met Covered as In-Network Covered as In-Network Covered as In-Network
<u>Outpatient Mental Health and Substance Use Disorder Services at a Facility</u> Facility Fees Doctor Services	20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
<u>Outpatient Surgery</u> Facility Fees Hospital Physician and other services <i>including surgeon fees</i> Hospital	20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical 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>	20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% 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
Physician and other services <i>including surgeon fees</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Home Health Care <i>Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Therapy Services Rehabilitation and Habilitation services <i>Coverage for Physical and Occupational Therapies is limited to 30 visits each per benefit period.</i> Office Outpatient Hospital <i>Coverage for Speech Therapy is limited to 20 visits per benefit period.</i> Office Outpatient Hospital Manipulation Therapy <i>Coverage is limited to 12 visits per benefit period.</i> Office Outpatient Hospital	 \$30 copay per visit medical deductible does not apply 20% coinsurance after medical deductible is met \$60 copay per visit medical deductible does not apply 20% coinsurance after medical deductible is met \$30 copay per visit medical deductible does not apply 20% coinsurance after medical deductible is met	 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
Pulmonary rehabilitation <i>Coverage is limited to 20 visits per benefit period.</i> Office Outpatient Hospital	 \$60 copay per visit medical deductible does not apply 20% coinsurance after medical deductible is met	 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
Cardiac rehabilitation <i>Coverage is limited to 36 visits per benefit period.</i>		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Office	\$60 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Dialysis/Hemodialysis		
Office	\$60 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Chemo/Radiation Therapy		
Office	\$60 copay per visit medical deductible does not apply [‡]	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Skilled Nursing Care (facility) <i>Coverage for Skilled Nursing is limited to 90 days per benefit period. Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 60 days per benefit period.</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Inpatient Hospice	20% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
<u>Additional Services, Equipment and Devices</u>		
Durable Medical Equipment	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prosthetic Devices	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Wigs <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Hearing Aids (for members through age 21) <i>Coverage is limited to 1 hearing aid per hearing impaired ear every 48 months including wearable and bone anchored hearing aids with a dollar maximum of \$2,500 per ear.</i>	No charge	40% 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 Pharmacy
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Out-of-Network medical out-of-pocket limit
<u>Prescription Drug Coverage</u> Network: Base Network Drug List: National For more information, refer to “National Drug List” at https://www.anthem.com/pharmacy-information/.		
<u>Day Supply Limits</u> 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.		
Tier 1 - Typically Generic	\$15 copay per prescription (retail) and \$30 copay per prescription (home delivery)	\$15 copay per prescription (retail) and Not covered (home delivery)
Tier 2 - Typically Preferred Brand	\$50 copay per prescription (retail) and \$100 copay per prescription (home delivery)	\$50 copay per prescription (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand & Specialty	\$90 copay per prescription (retail) and \$180 copay per prescription (home delivery)	\$90 copay per prescription (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.
- 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.
- † You will pay your PCP or Specialist office visit copay for certain services provided in their office.
- 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.
- 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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