Your summary of benefits

Anthem

Anthem® Blue Cross and Blue Shield

Western Reserve Care Solutions

Your Plan: Anthem Blue Connection HMO

Your Network: Blue Connection

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 medical deductible does not apply
Mental Health & Substance Use Disorder Services	No charge medical deductible does not apply
Specialist care	$30 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	$250 person / $500 family	Not covered
Overall Out-of-Pocket Limit	$2,000 person / $6,000 family	Not covered
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.		
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	Not covered
Specialist Provider *virtual and office*	$30 copay per visit medical deductible does not apply	Not covered
Other Practitioner Visits		
Maternity Doctor services (prenatal/postpartum care and delivery)	0% coinsurance after medical deductible is met	Not covered
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	Not covered

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	0% coinsurance after medical deductible is met	Not covered
Prescription Drugs *Dispensed in the office*	0% coinsurance after medical deductible is met	Not covered
Surgery	0% coinsurance after medical deductible is met	Not covered
Preventive care / screenings / immunizations	No charge	Not covered
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	Not covered
Diagnostic Services Lab		
Office	0% coinsurance after medical deductible is met	Not covered
Freestanding Lab/Reference Lab	No charge	Not covered
Outpatient Hospital	0% coinsurance after medical deductible is met	Not covered
Diagnostic Services X-Ray		
Office	0% coinsurance after medical deductible is met	Not covered
Freestanding Radiology Center	0% coinsurance after medical deductible is met	Not covered
Outpatient Hospital	0% coinsurance after medical deductible is met	Not covered
Diagnostic Services Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	0% coinsurance after medical deductible is met	Not covered
Freestanding Radiology Center	0% coinsurance after medical deductible is met	Not covered
Outpatient Hospital	0% coinsurance after medical deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	$20 copay per visit medical deductible does not apply	Covered as In-Network
Emergency Room Facility Services *Your copay will be waived if admitted.*	$125 copay per visit after medical deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	Covered as In-Network
Ambulance *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.*	$50 copay per trip after medical deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	No charge	Not covered
Doctor Services	No charge	Not covered
Outpatient Surgery		
Facility Fees		
Hospital	0% coinsurance after medical deductible is met	Not covered
Ambulatory Surgical Center	0% coinsurance after medical deductible is met	Not covered
Physician and other services *including surgeon fees*		
Hospital	0% coinsurance after medical deductible is met	Not covered
Ambulatory Surgical Center	0% coinsurance after medical deductible is met	Not covered
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)		
Facility Fees	0% coinsurance after medical deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
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.*	0% coinsurance after medical deductible is met	Not covered
Physician and other services *including surgeon fees*	0% coinsurance after medical deductible is met	Not covered
Home Health Care & Private Duty Nursing *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	0% coinsurance after medical deductible is met	Not covered
Therapy Services		
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for physical, occupational, and speech therapies is limited to 30 visits each per benefit period.*		
Office	$20 copay per visit medical deductible does not apply	Not covered
Outpatient Hospital	$20 copay per visit medical deductible does not apply	Not covered
Manipulation Therapy *Coverage is limited to 12 visits per benefit period.*		
Office	$30 copay per visit medical deductible does not apply	Not covered
Outpatient Hospital	$30 copay per visit medical deductible does not apply	Not covered
Pulmonary rehabilitation *office and outpatient hospital* *Coverage is limited to 20 visits per benefit period.*	$20 copay per visit medical deductible does not apply	Not covered
Cardiac rehabilitation *office and outpatient hospital* *Coverage is limited to 36 visits per benefit period.*	$20 copay per visit medical deductible does not apply	Not covered
Dialysis/Hemodialysis *office and outpatient hospital*	0% coinsurance after medical deductible is met	Not covered
Chemo/Radiation Therapy		
Office	$30 copay per visit medical deductible does not apply‡	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Hospital	$20 copay per visit medical deductible does not apply	Not covered
Skilled Nursing Care (facility) *Coverage for Skilled Nursing is 100 days per benefit period and Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 60 days per benefit period.*	0% coinsurance after medical deductible is met	Not covered
Inpatient Hospice	0% coinsurance after medical deductible is met	Not covered
Additional Services, Equipment and Devices		
Durable Medical Equipment	0% coinsurance after medical deductible is met	Not covered
Prosthetic Devices	0% coinsurance after medical deductible is met	Not covered
Wigs *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	0% coinsurance after medical deductible is met	Not covered
Hearing Aids	No charge	Not covered

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 covered
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Not covered
Prescription Drug Coverage **Network:** ***Base Network*** **Drug List:** ***National Direct Plus*** *If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.*		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at Preferred Network and 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 may get two 30-day supply fills of the same maintenance medication at a retail pharmacy. Prior to your 3rd fill, you must call us on the number on your ID card and tell us if you would like to keep getting your maintenance medications from a retail pharmacy or if you would like to use home delivery. If you do not contact us, you will pay the full retail cost of any maintenance medication until you inform us of your decision.*		

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
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)	Not covered (retail and home delivery)
Tier 2 - Typically Preferred Brand	$35 copay per prescription (retail) and $70 copay per prescription (home delivery)	Not covered (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand	$40 copay per prescription (retail) and $80 copay per prescription (home delivery)	Not covered (retail and home delivery)
Tier 4 - Typically Specialty (brand and generic)	$35 copay per prescription (retail and home delivery)	Not covered (retail and home delivery)

Notes:

- Dependent Age Limit: to the end of the month in which the child attains age 26.
- No charge means no deductible / copayment / coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount.
- 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.
- 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 Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.

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Questions: (833) 639-1634 or visit us at www.anthem.com

Your summary of benefits

Anthem

Your Plan: **Anthem Blue Connection HMO $250**

Your Network: Blue Connection

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