

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your 2026 Contract Code: 90ZQ

Your Plan: SOCA BP Blue Access PPO 7500E/0%/7500 w/HSA PrevRx

Your Network: Blue Access

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. Unless stated otherwise, the limitations for In- and Out-of-Network services are combined and services received in an office, Ambulatory Surgical Center, or outpatient facility are combined across all outpatient settings. 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 Certificate of Insurance or Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

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	No charge 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	\$7,500 person / \$15,000 family	\$22,500 person / \$45,000 family
Overall Out-of-Pocket Limit <i>When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period.</i>	\$7,500 person / \$15,000 family	\$26,250 person / \$52,500 family
<i>The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per member deductible and per member 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 member deductible or per member out-of-pocket limit.</i>		
<i>In-Network and Out-of-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.</i>		
<i>All medical and pharmacy deductibles, copayments and coinsurance apply to the out-of-pocket limit. However, member cost sharing for the following service(s) do not apply toward the out-of-pocket limit: Out-of-Network Human Organ and Tissue Transplant, and Cellular and Gene Therapy.</i>		
<i>For HSA compatible CDHP plans, any applicable Medical or Pharmacy copayments apply after the deductible has been met and accumulate to the Overall Out-of-Pocket Limit.</i>		
Doctor Visits (virtual and office) <i>You are encouraged to select a Primary Care Physician (PCP).</i>		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Primary Care (PCP) and Mental Health and Substance Use Disorder Services <i>virtual and office</i> Specialist Provider <i>virtual and office</i>	No charge after deductible is met	50% coinsurance after deductible is met
Other Practitioner Visits Maternity Doctor services (prenatal/postpartum care and delivery) <i>In-Network preventive prenatal services are covered at 100%.</i> Retail Health Clinic	No charge after deductible is met	50% coinsurance after deductible is met
Other Services in an Office Allergy Testing Prescription Drugs - Dispensed in the office <i>For the drugs itself dispensed in the office through infusion/injection.</i> Surgery	No charge after deductible is met	50% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	50% coinsurance after deductible is met
Preventive care for Chronic Conditions <i>per IRS guidelines</i>	No charge	Cost share is based on the setting services are received.
<u>Diagnostic Services Lab</u> Office Freestanding Lab/Reference Lab	No charge after deductible is met	50% 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
Outpatient Hospital	No charge after deductible is met	50% coinsurance after deductible is met
<u>Diagnostic Services X-Ray</u>		
Office	No charge after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	No charge after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	No charge after deductible is met	50% coinsurance after deductible is met
<u>Diagnostic Services Advanced Diagnostic Imaging</u> - for example: MRI, PET and CAT scans		
Office	No charge after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	No charge after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	No charge after deductible is met	50% coinsurance after deductible is met
<u>Emergency and Urgent Care</u>		
Urgent Care (Office Setting)	No charge after deductible is met	50% coinsurance after deductible is met
Emergency Room Facility Services	No charge after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	No charge after deductible is met	Covered as In-Network
Ambulance (Air and Ground) <i>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.</i>	No charge after deductible is met	Covered as In-Network
<u>Outpatient Mental Health and Substance Use Disorder Services at a Facility</u>		
Facility Fees	No charge after deductible is met	50% 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
Doctor Services	No charge after deductible is met	50% coinsurance after deductible is met
<u>Outpatient Surgery</u>		
Facility Fees		
Hospital	No charge after deductible is met	50% coinsurance after deductible is met
Ambulatory Surgical Center	No charge after deductible is met	50% coinsurance after deductible is met
Physician and other services including surgeon fees		
Hospital	No charge after deductible is met	50% coinsurance after deductible is met
Ambulatory Surgical Center	No charge after deductible is met	50% coinsurance after deductible is met
<u>Hospital Stay (all Inpatient stays including Maternity, Mental Health and Substance Use Disorder Services)</u>		
Facility fees (for example, room & board) <i>Coverage for Skilled Nursing and Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 150 days combined per benefit period.</i>	No charge after deductible is met	50% coinsurance after deductible is met
Physician and other services including surgeon fees	No charge after deductible is met	50% coinsurance after deductible is met
<u>Home Health Care</u> <i>Home health visits are limited to 100 visits per benefit period. Limits are combined for home health care and private duty nursing. Benefit limit and cost share applies to physical, occupational, speech, respiratory, cardiac and pulmonary therapy when performed as part of Home Health.</i>	No charge after deductible is met	50% coinsurance after deductible is met
<u>Therapy Services</u>		
Rehabilitation services (for example, physical/speech/occupational therapy) <i>Coverage for rehabilitative and habilitative occupational therapy is limited to 20 visits per benefit period, rehabilitative and habilitative physical therapy is limited to 20 visits per benefit period and rehabilitative and habilitative speech therapy is limited to 20 visits per benefit period. Coverage for rehabilitative and habilitative occupational therapy is limited to 20 visits combined 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	No charge after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	No charge after deductible is met	50% coinsurance after deductible is met
Habilitation services (for example, physical/speech/occupational therapy) <i>Coverage for rehabilitative and habilitative occupational therapy is limited to 20 visits per benefit period, rehabilitative and habilitative physical therapy is limited to 20 visits per benefit period and rehabilitative and habilitative speech therapy is limited to 20 visits per benefit period. Coverage for rehabilitative and habilitative occupational therapy is limited to 20 visits combined per benefit period.</i>		
Office	No charge after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	No charge after deductible is met	50% coinsurance after deductible is met
Chiropractic office and outpatient hospital <i>Coverage is limited to 12 visits per benefit period.</i>	No charge after deductible is met	50% coinsurance after deductible is met
Pulmonary rehabilitation office and outpatient hospital <i>Coverage is limited to 20 visits per benefit period.</i>	No charge after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation office and outpatient hospital <i>Coverage is limited to 36 visits per benefit period.</i>	No charge after deductible is met	50% coinsurance after deductible is met
Dialysis/Hemodialysis office and outpatient hospital	No charge after deductible is met	50% coinsurance after deductible is met
Chemo/Radiation Therapy office and outpatient hospital	No charge after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (in a facility) <i>Coverage for Skilled Nursing and Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 150 days combined per benefit period.</i>	No charge after deductible is met	50% coinsurance after deductible is met
Inpatient Hospice	No charge after deductible is met	50% 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
Durable Medical Equipment	No charge after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period. Hearing aids for members through age 21 are limited to 1 item, up to \$2,500 per hearing-impaired ear, every 48 months, and when purchased from an In-Network provider, benefits are covered in full after deductible is met.</i>	No charge after deductible is met	50% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	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 In-Network medical deductible	Combined with Out-of-Network medical deductible
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical 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: Rx Choice Tiered Network Drug List: Essential <i>Drugs not included on the Essential drug list will not be covered. Prescription Drugs that we are required to cover by federal law under the "Preventive Care" benefit will be covered with no deductible, copayments or coinsurance when you use an In-Network Pharmacy.</i>			
Day Supply Limits: Retail Pharmacy 30 day supply (cost shares noted below) Retail 90 Pharmacy 90 day supply (cost shares noted below) 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. 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.			
Preventive Drugs <i>See cost shares below for Prescription Drugs on the PreventiveRX Basic Plus list.</i>			
Tier 1 Preventive - Typically Generic <i>Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies.</i>	\$15 copay per prescription, deductible does not apply (retail)		Not covered (retail and home delivery)
Tier 2 Preventive - Typically Preferred Brand <i>Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies.</i>	\$45 copay per prescription, deductible does not apply (retail)		Not covered (retail and home delivery)
Tier 1 - Typically Generic	0% coinsurance after deductible is met (retail and home delivery)	0% coinsurance after deductible is met (retail only)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 - Typically Preferred Brand	0% coinsurance after deductible is met (retail and home delivery)	0% coinsurance after deductible is met (retail only)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Tier 3 - Typically Non-Preferred Brand	0% coinsurance after deductible is met (retail and home delivery)	0% coinsurance after deductible is met (retail only)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	0% coinsurance after deductible is met (retail and home delivery)	0% coinsurance after deductible is met (retail only)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)

Healthy Support & Rewards

To see your rewards and additional information log into the Anthem website at [anthem.com](https://www.anthem.com) or call the customer service number on your member ID card.

Program Name	Program Description	Program Incentive
Smart Rewards (Wellbeing Solutions Engagement Package 200)	Subscriber and spouse/domestic partner may earn rewards when eligible activities are completed and, in some instances, are verified by an Anthem claim.	Up to \$200 per member per year

Notes:

- Benefit period refers to calendar year.
- For additional information on this plan, please visit www.sbc.anthem.com to obtain a “Summary of Benefits and Coverage”.
- If services are rendered by a non-participating provider and your plan includes Out-of-Network benefits, you may be responsible for any difference between the covered plan payment and the actual non-participating provider’s charge.
- 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.
- Covered dependents are covered through the end of the month in which the child attains age 26.
- Limitations and Cost shares may vary by site of service. You should refer to your formal contract of coverage for details.
- No Charge means you will not have to pay deductible, copayment and/or coinsurance cost shares up to the maximum allowable amount.
- Primary Care Physician (PCP) is a professional provider who is a practitioner who specializes in family practice, general practice, internal medicine, pediatrics, geriatrics or any other professional provider as allowed by the plan.
- Specialty Provider (SCP) is a professional provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
- 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.
- Covered accidental dental services are covered up to \$3,000 per member per episode.
- Certain diabetic and asthmatic supplies are covered subject to applicable prescription drug copayments / coinsurance when received from an In-Network pharmacy. These supplies are covered as medical supplies and durable medical equipment if received from an Out-of-Network pharmacy. Diabetic test strips are covered subject to applicable prescription drug copayment / coinsurance.
- Human Organ and Tissues Transplants require precertification.
- You must get certain covered transplant procedures from an Approved In-Network Provider to receive the In-Network level of benefits.
- Maternity hospital stays will not be limited to less than 48 hours for a vaginal delivery or 96 hours for a caesarean section.
- Oral Chemo Mandate applies, and requires parity for cost shares for oral chemo drugs with intravenously administered/injected cancer medications.
- This health plan includes an Employee Assistance Program (EAP) to support your emotional health and wellness with work life resources, including one-on-one counseling by phone, in person and online. Three counseling visits are available at no charge to a member. EAP member service is accessible 24/7/365.
- Acupuncture, Bariatric Surgery, Infertility treatment are not covered.

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Questions: (844) 412-0889 or visit us at www.anthem.com

OH/MEWA/SOCA BP Blue Access PPO 7500E/0%/7500 w/HSA PrevRx/90ZQ/2026

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 장애인 이신가요? 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>