EPC BENEFIT PLAN SUMMARY – ANTHEM BLUE ACCESS PPO

District: **Arcanum-High Option**

Dependents: Spouse and unmarried children to age 19. From age 19 to 24 (end of calendar year): fulltime student or unemployed IRS qualified dependent.

More information: Anthem Customer Service 1 800-552-9159 or www.Anthem.com

This is a **P**referred **P**rovider **O**rganization plan with a Network of medical providers who have contracts with Anthem. You will pay less out of pocket by using Network providers.

Covered Benefits	Network	Non-Network [4]
Deductible (Single/Family max) [1]	$100/$200	$200/$400
Out of Pocket Maximum (Single/Family max) [2]	$1,000/$2,000	$2,000/$4,000
Physician Office Services Including Office Surgeries, allergy serum and injections	$15 co-pay	20%
Preventive Care Medical History Pelvic Exams, Pap tests and PSA tests Mammography, Immunizations [3] Annual diabetic eye exam Annual Vision & Hearing exams	$15 co-pay	20%
Outpatient Physical Medicine Therapies (Cal. Yr. limits apply to Network + Non-Network services) Physical/Occupational therapy: 30/30 visit limit Spinal manipulations: 12 visit limit Speech therapy: 20 visit limit	Co-payments based on place of service – office or out patient.	Co-payments based on place of service – office or out patient.
Inpatient Services Unlimited days except for: 60 days for physical medicine/rehab 180 days for skilled nursing facility (Calendar year limits apply to Network + Non-Network services)	Covered in full	20%
Outpatient Surgery Hospital/Alternative Care Facility	Covered in full	20%
Other Outpatient Services Hospital/Alternative Care Facility	Covered in full	20%
Inpatient and Outpatient Professional Services	Covered in full	20%
Home Care Services	Covered in full	20%
Emergency and Urgent Care: Emergency Room (waived if admitted) Urgent Care Facility	 $50 co-pay $25 co-pay	 $50 co-pay $25 co-pay
Ambulance Services	Covered in full	Covered in full
Maternity Services	Covered in full	20%

Medical Supplies, Equipment and Appliances	20%	40%
Mental Health and Substance Abuse (see notes below [6]) Inpatient 30 days max Network + Non-Network Outpatient: 50 Network visits 10 Non-Network visits Substance Abuse: Inpatient + Outpatient Non-Network, $550 max Call 1 800-788-4003 for authorized referral	Covered in full Co-payments based on place of service	20% Co-payments based on place of service
Lifetime Maximum combined Network + Non-Network	$5,000,000	
Human Organ Transplants (see note below [7]) Separate $1,000,000 max applies	Covered in full	50%
Prescription Drug Options [5] Retail Pharmacies – 30 day supply Anthem Rx Direct Mail Service – 60 day supply	Tier 1: $10 Tier 2: $20 Tier 3: $30 same co-pays	50%, minimum $30 Not covered

The most recent plan changes were effective: October 1, 2005.

More details: This is a brief summary of benefits. For plan details and exclusions which may apply, please refer to your Certificate of Coverage or call Customer Service. In the event of a conflict between this summary and the Group Contract, the terms of the Group Contract will prevail.

[1] **Deductible**: The deductible applies to expenses that are paid at a percentage less than 100%, unless noted otherwise. The family deductible caps deductible expenses for a family. No more than the single deductible amount will be applied to an individual.

[2] **Out of Pocket Maximum**: This is the sum of covered expenses which you are liable to pay during a calendar year – your Maximum Out-of-Pocket expenses. The Out of Pocket max includes deductibles and coinsurance (the amount you pay as a percentage of the charge). It does not include copays such as office visit and Rx copays. Any Non-Network expenses that are over Anthem's Maximum Allowable Charge are not included in the Out of Pocket max. Also, any expenses that are not covered by the plan are not included.

When you reach your Out of Pocket maximum during the calendar year, additional covered expenses that would be paid at a percentage less than 100% will be paid at 100% for the remainder of the year.

Network and Non-Network deductibles, copayments and out-of-pocket maximums are separate and do not accumulate toward each other.

[3] Mammography and immunizations are covered at 100% if rendered without an office visit.

Network Providers: These are medical providers who have a contract with Anthem. They bill directly to Anthem, and you should not be charged more than your share of the cost according to the Network column. Anthem's network is **national** and includes some **international** providers. For a current list of Anthem providers refer to www.Anthem.com. For expenses paid at a percentage less than 100%, payment is based on the Anthem discounted amount.

[4] **Non-Network Providers**: Non Network providers do not have contracts with Anthem and can bill you according to their own fee schedule which may exceed Anthem's Maximum Allowable Charge (MAC). The percentage that Anthem pays Non-Network is based on the MAC, not the amount billed by the

provider. Non-Network providers can bill you for the amount their fee exceeds the MAC. **Always** contact Anthem to pre-certify Non-Network hospitalization or potentially expensive services.

[5] **Rx:** **Mail Order:** For mail order forms and instructions go to www.Anthem.com
Tier 1: Usually generic Rx that are on Anthem's preferred drug list
Tier 2: Usually brand name Rx that are on Anthem's preferred drug list
Tier 3: Usually Rx that are **not** on Anthem's preferred drug list
For complete information on the Rx list go to www.Anthem.com
Non Network Rx: Diabetic and asthmatic supplies are not covered Non-Network except for diabetic test strips.

[6] **Mental Health**: Mental health / substance abuse must be authorized by the mental health administrator for services to be covered at the highest level. Call 1 800-788-4003 for authorized referral. Substance abuse rehabilitation programs are limited to 2 per lifetime, Network and Non-Network combined.

[7] **Human Organ Transplants**: Kidney and cornea transplants are covered the same as any other illness and are not included under the organ transplant benefit.

EPC BENEFIT PLAN SUMMARY – ANTHEM BLUE ACCESS PPO

District: **Arcanum- Core Option**

Dependents: Spouse and unmarried children to age 19. From age 19 to 24 (end of calendar year): fulltime student or unemployed IRS qualified dependent.

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Covered Benefits	Network	Non-Network [4]
Deductible (Single/Family max) [1]	$100/$200	$200/$400
Out of Pocket Maximum (Single/Family max) [2]	$750/$1,500	$1,500/$3,000
Physician Office Services Including Office Surgeries, allergy serum and injections	$20 co-pay	20%
Preventive Care Medical History Pelvic Exams, Pap tests and PSA tests Mammography, Immunizations [3] Annual diabetic eye exam Annual Vision & Hearing exams	$20 co-pay	20%
Outpatient Physical Medicine Therapies (Cal. Yr. limits apply to Network + Non-Network services) Physical/Occupational therapy: 30/30 visit limit Spinal manipulations: 12 visit limit Speech therapy: 20 visit limit	Co-payments based on place of service – office or out patient.	Co-payments based on place of service – office or out patient.
Inpatient Services Unlimited days except for: 60 days for physical medicine/rehab 180 days for skilled nursing facility (Calendar year limits apply to Network + Non-Network services)	10%	30%
Outpatient Surgery Hospital/Alternative Care Facility	10%	30%
Other Outpatient Services Hospital/Alternative Care Facility	10%	30%
Inpatient and Outpatient Professional Services	10%	30%
Home Care Services	10%	30%
Emergency and Urgent Care: Emergency Room (waived if admitted) Urgent Care Facility	$75 co-pay $35 co-pay	$75 co-pay $35 co-pay
Ambulance Services	**10%**	**30%**

Maternity Services	10%	**30%**
Medical Supplies, Equipment and Appliances	**20%**	**40%**
Mental Health and Substance Abuse (see notes below [6]) **Inpatient 30 days max Network + Non-Network** **Outpatient: 50 Network visits** **10 Non-Network visits** **Substance Abuse: Inpatient + Outpatient Non-Network, $550 max** **Call 1 800-788-4003 for authorized referral**	**10%** **Co-payments based on place of service**	**30%** **Co-payments based on place of service**
Lifetime Maximum combined Network + Non-Network	$5,000,000	
Human Organ Transplants (see note below [7]) Separate $1,000,000 max applies	**10%**	50%
Prescription Drug Options [5] Retail Pharmacies – 30 day supply Anthem Rx Direct Mail Service – 60 day supply	Tier 1: $10 Tier 2: $20 Tier 3: $30 same co-pays	50%, minimum $30 Not covered

The most recent plan changes were effective: October 1, 2007.

More details: This is a brief summary of benefits. For plan details and exclusions which may apply, please refer to your Certificate of Coverage or call Customer Service. In the event of a conflict between this summary and the Group Contract, the terms of the Group Contract will prevail.

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When you reach your Out of Pocket maximum during the calendar year, additional covered expenses that would be paid at a percentage less than 100% will be paid at 100% for the remainder of the year.

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