

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access PPO HSA

Your Network: Blue Access

Indiana State Medical Association - Individuals

Effective: 01/01/2023

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$3,000 person / \$6,000 family	\$5,000 person / \$10,000 family
Overall Out-of-Pocket Limit	\$4,000 person / \$8,000 family	\$10,000 person / \$20,000 family
<p>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.</p> <p>Your copays, coinsurance and deductible count toward your out of pocket limit(s).</p> <p>In-Network and Non-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.</p>		
<p>Doctor Visits (virtual and office) <i>You are encouraged to select a Primary Care Physician (PCP).</i></p>		
<p>Medical Chats and Virtual Visits for Primary Care <i>from our Online Provider K Health, through its affiliated Provider groups are covered at 0% coinsurance per visit after deductible is met.</i></p>		
<p>Virtual Visits from online provider LiveHealth Online <i>for urgent/acute medical and mental health and substance abuse care via www.livehealthonline.com are covered at 20% coinsurance after deductible is met.</i></p>		
<p>Primary Care (PCP) and Mental Health and Substance Abuse Care <i>virtual and office</i></p>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<p>Specialist Care <i>virtual and office</i></p>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<p><u>Other Practitioner Visits</u></p>		
<p>Routine Maternity Care (Prenatal and Postnatal)</p>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<p>Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i></p>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<p>Manipulation Therapy <i>Coverage is limited to 12 visits per benefit period.</i></p>	20% coinsurance 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 a Non-Network Provider
<p><u>Other Services in an Office</u></p> <p>Allergy Testing</p> <p>Prescription Drugs <i>Dispensed in the office</i></p> <p>Surgery</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p>Preventive care / screenings / immunizations</p>	<p>No charge</p>	<p>50% coinsurance after deductible is met</p>
<p>Preventive Care for Chronic Conditions <i>per IRS guidelines</i></p>	<p>No charge</p>	<p>50% coinsurance after deductible is met</p>
<p><u>Diagnostic Services</u></p> <p>Lab</p> <p>Office</p> <p>Freestanding Lab/Reference Lab</p> <p>Outpatient Hospital</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p>X-Ray</p> <p>Office</p> <p>Outpatient Hospital</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p>Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i></p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><u>Emergency and Urgent Care</u></p> <p>Urgent Care</p>	<p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency Room Facility Services Emergency Room Doctor and Other Services Ambulance	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	Covered as In-Network Covered as In-Network Covered as In-Network
<u>Outpatient Mental Health and Substance Abuse Care at a Facility</u> Facility Fees Doctor Services	20% coinsurance after deductible is met 20% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met
<u>Outpatient Surgery</u> Facility Fees Hospital Ambulatory Surgical Center Doctor and Other Services Hospital Ambulatory Surgical Center	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met
<u>Hospital (Including Maternity, Mental Health and Substance Abuse)</u> Facility Fees Human Organ and Tissue Transplants <i>Cornea transplants are treated the same as any other illness and subject to the medical benefits.</i> Physician and other services <i>including surgeon fees</i>	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met
Home Health Care <i>Coverage is limited to 100 visits per benefit period.</i>	20% coinsurance 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 a Non-Network Provider
<p>Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies.</i> <i>Coverage for physical and occupational therapies is limited to 60 visits combined per benefit period. Coverage for speech therapy is limited to 20 visits per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p>Pulmonary rehabilitation <i>office and outpatient hospital</i> <i>Coverage is limited to 20 visits per benefit period.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p>
<p>Cardiac rehabilitation <i>office and outpatient hospital</i> <i>Coverage is limited to 36 visits per benefit period.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p>
<p>Dialysis/Hemodialysis <i>office and outpatient hospital</i></p>	<p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p>
<p>Chemo/Radiation Therapy <i>office and outpatient hospital</i></p>	<p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p>
<p>Skilled Nursing Care (facility) <i>Coverage for Skilled Nursing is limited to 90 days per benefit period.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p>
<p>Inpatient Hospice</p>	<p>20% coinsurance after deductible is met</p>	<p>Covered as In-Network</p>
<p>Durable Medical Equipment</p>	<p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p>
<p>Prosthetic Devices <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p>

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use a Non-Network Pharmacy
<p>Pharmacy Deductible</p>	<p>Combined with In-Network medical deductible</p>	<p>Combined with Non-Network medical deductible</p>

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Prescription Drug Coverage Network: <i>Base Network</i> Drug List: <i>National Drugs not included on the drug list will not be covered.</i>		
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 CarelonRx Mail (IngenioRx will become CarelonRx on January 1, 2023). 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.		
Tier 1 - Typically Generic	20% coinsurance after deductible is met (retail and home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand	20% coinsurance after deductible is met (retail and home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	20% coinsurance after deductible is met (retail and home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	20% coinsurance after deductible is met (retail and home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)

Notes:

- Dependent age: to end of the year in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using non-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 a Non-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.

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.

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:

If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (833) 578-4441

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

(TTY/TDD: 711)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (833) 578-4441.

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (833) 578-4441:

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Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (833) 578-4441.

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Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(833) 578-4441로 문의하십시오.

Language Access Services:

Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'idiikidgo ná bohónéedzǎ dóó bee ahóót'i' t'áá ni nizaad k'ehǫ́ bee nił hodoonih t'áadoo bǫ́áh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih ninízingo kojí' hodíílnih (833) 578-4441.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: (833) 578-4441.

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