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: 01/01/2022

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *The deductible for In-Network and Non-Network are added separately and do not apply towards each other.*	$3,000 person / $6,000 family	$5,000 person / $10,000 family
Out-of-Pocket Limit *The Out-of-Pocket limit for In-Network and Non-Network are added separately and do not apply towards each other.*	$4,000 person / $8,000 family	$10,000 person / $20,000 family
The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.		
Preventive Care / Screening / Immunization	No charge	50% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Specialist Care Visit	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Prenatal and Post-natal Care	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	20% coinsurance after deductible is met	50% coinsurance after deductible is met
On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 12 visits per benefit period.*	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
Other Services in an Office:		
Allergy Testing	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Chemo/Radiation Therapy	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Dialysis/Hemodialysis	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Prescription Drugs - *Dispensed in the office*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Diagnostic Services **Lab:**		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Lab/Reference Lab	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
X-Ray:		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging:		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	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
Emergency and Urgent Care		
Urgent Care	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency Room Facility Services	20% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	Covered as In-Network
Ambulance	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Facility visit:		
Facility Fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	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
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):		
Facility fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Human Organ and Tissue Transplants *Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 100 visits per benefit period.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services:		
Office *Coverage for Physical & Occupational Therapy is combined 60 visits per benefit period. Speech Therapy is limited to 20 visits per benefit period.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital *Coverage for Physical & Occupational Therapy is combined 60 visits per benefit period. Speech Therapy is limited to 20 visits per benefit period.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation		
Office *Coverage is limited to 36 visits per benefit period.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital *Coverage is limited to 36 visits per benefit period.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (facility) *Skilled Nursing is limited to 90 days per benefit period. Limit is combined In-Network and Non-Network. Benefit includes coverage for Outpatient Rehabilitation program.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospice	20% coinsurance after deductible is met	Covered as In-Network
Durable Medical Equipment	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
Prosthetic Devices	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with Non-Network medical deductible
Pharmacy Out of Pocket	Combined with In-Network medical	Combined with Non-Network medical
Prescription Drug Coverage *National Network w/R90 with Optional Home Delivery* *National Drug List*		
Tier 1 - Typically Generic *30 day supply (retail pharmacy). 90 day supply (home delivery).*	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 *30 day supply (retail pharmacy). 90 day supply (home delivery).*	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 *30 day supply (retail pharmacy). 90 day supply (home delivery).*	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) *30 day supply (retail pharmacy). 30 day supply (home delivery).*	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.
- All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum.
- 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 your plan includes out-of-network benefits, In-network and out-of-network deductibles, copayments, coinsurance and out-of-pocket maximum amounts are separate and do not accumulate toward each other.
- 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" which is generally coinsurance or coinsurance after your deductible is met.

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.

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

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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

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(TTY/TDD: 711)

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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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Language Access Services:

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Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'ídiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ąh ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínízingo kojį' hodíílnih (833) 578-4441.

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