Your summary of benefits

Anthem®

Anthem® Blue Cross and Blue Shield

Central Indiana School Employees Insurance Trust

Effective 01/01/2023

Your Plan: Anthem 3 Tier POS Plan

Your Network: 3 Tier POS Plan

Covered Medical Benefits	Cost if you use an In-Network Provider (Tier 1 – Hendricks Regional Hospital)	Cost if you use an In-Network Provider (Tier 2 – Blue Access/BlueCard)	Cost if you use a Non-Network Provider
Overall Deductible	$1,000 person / $2,500 family	$1,500 person / $3,000 family	$4,500 person/ $9,000 family
Overall Out-of-Pocket Limit	$3,000 person / $6,000 family	$3,500 person / $7,000 family	$10,500 person/ $21,000 family
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. Your copays, coinsurance and deductible count toward your out of pocket limit(s). In-Network and Non-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.			
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*			
Medical Chats and Virtual Visits for Primary Care *from our Online Provider K Health, through its affiliated Provider groups are covered at 0% coinsurance per visit medical deductible does not apply.*			
Virtual Visits from online provider LiveHealth Online *for urgent/acute medical and mental health and substance abuse care via www.livehealthonline.com are covered at 20% coinsurance per visit medical deductible does not apply.*			
Primary Care (PCP) and Mental Health and Substance Abuse Care *virtual and office*	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Specialist Care *virtual and office*	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Other Practitioner Visits			
Routine Maternity Care (Prenatal and Postnatal)	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider (Tier 1 – Hendricks Regional Hospital)	Cost if you use an In-Network Provider (Tier 2 – Blue Access/BlueCard)	Cost if you use a Non-Network Provider
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Manipulation Therapy *Coverage is unlimited visits per benefit period*	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Other Services in an Office			
Allergy Testing	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prescription Drugs *Dispensed in the office*	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Surgery	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Preventive care / screenings / immunizations	No charge	No charge	40% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	No charge	40% coinsurance after medical deductible is met
Diagnostic Services **Lab**			
Office	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Freestanding Lab/Reference Lab	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
X-Ray			
Office	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider (Tier 1 – Hendricks Regional Hospital)	Cost if you use an In-Network Provider (Tier 2 – Blue Access/BlueCard)	Cost if you use a Non-Network Provider
Outpatient Hospital	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*			
Office	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Freestanding Radiology Center	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Emergency and Urgent Care			
Urgent Care	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Emergency Room Facility Services	10% coinsurance after medical deductible is met	Covered as In-Network	Covered as In-Network
Emergency Room Doctor and Other Services	10% coinsurance after medical deductible is met	Covered as In-Network	Covered as In-Network
Ambulance	10% coinsurance after medical deductible is met	Covered as In-Network	Covered as In-Network
Outpatient Mental Health and Substance Abuse Care at a Facility			
Facility Fees	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Doctor Services	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider (Tier 1 – Hendricks Regional Hospital)	Cost if you use an In-Network Provider (Tier 2 – Blue Access/BlueCard)	Cost if you use a Non-Network Provider
Outpatient Surgery			
Facility Fees			
Hospital	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Ambulatory Surgical Center	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Doctor and Other Services			
Hospital	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Ambulatory Surgical Center	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)			
Facility Fees	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Human Organ and Tissue Transplants *Cornea transplants are treated the same as any other illness and subject to the medical benefits.*	No charge	No charge	40% coinsurance after medical deductible is met
Physician and other services *including surgeon fees*	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Home Health Care *Coverage is unlimited visits per benefit period.*	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for physical and occupational therapies is unlimited visits per benefit period. Coverage for speech therapy is unlimited visits per benefit period.*			
Office	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider (Tier 1 – Hendricks Regional Hospital)	Cost if you use an In-Network Provider (Tier 2 – Blue Access/BlueCard)	Cost if you use a Non-Network Provider
Outpatient Hospital	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Pulmonary rehabilitation *office and outpatient hospital* *Coverage is unlimited visits per benefit period.*	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Cardiac rehabilitation *office and outpatient hospital* *Coverage is unlimited visits per benefit period.*	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Chemo/Radiation Therapy *office and outpatient hospital*	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Coverage for Skilled Nursing is unlimited per benefit period.*	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Inpatient Hospice	No charge	No charge	No charge
Durable Medical Equipment	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item $500 after medical treatment per benefit period.*	10% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Notes:

- Dependent age: to end of the month 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.