

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Central Indiana School Employees Insurance Trust

Effective 01/01/2023

Your Plan: Anthem Blue Access PPO HSA

Your Network: Blue Access

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$3,500 person / \$7,000 family	\$7,000 person / \$14,000 family
Overall Out-of-Pocket Limit	\$3,500 person / \$7,000 family	\$14,000 person / \$28,000 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>		
Doctor Visits (virtual and office) <i>You are encouraged to select a Primary Care Physician (PCP).</i>		
Medical Chats and Virtual Visits for Primary Care <i>from our Online Provider K Health, through its affiliated Provider groups are covered at No charge after deductible is met.</i>		
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 0% coinsurance after deductible is met.</i>		
Primary Care (PCP) and Mental Health and Substance Abuse Care <i>virtual and office</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Specialist Care <i>virtual and office</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<u>Other Practitioner Visits</u>		
Routine Maternity Care (Prenatal and Postnatal)	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Manipulation Therapy <i>Coverage is unlimited visits per benefit period</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<u>Other Services in an Office</u>		
Allergy Testing	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Prescription Drugs <i>Dispensed in the office</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Surgery	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	30% coinsurance after deductible is met
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	30% coinsurance after deductible is met
<u>Diagnostic Services</u>		
Lab		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Lab/Reference Lab	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
X-Ray		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i>		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Radiology Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<u>Emergency and Urgent Care</u> Urgent Care Emergency Room Facility Services Emergency Room Doctor and Other Services Ambulance	0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met	30% 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	0% coinsurance after deductible is met 0% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met
<u>Outpatient Surgery</u> Facility Fees Hospital Ambulatory Surgical Center Doctor and Other Services Hospital Ambulatory Surgical Center	0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% 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 including surgeon fees	 0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met	 30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met
Home Health Care <i>Coverage is unlimited visits per benefit period.</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies.</i> <i>Coverage for physical and occupational therapies is unlimited visits per benefit period. Coverage for speech therapy is unlimited visits per benefit period.</i>		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Pulmonary rehabilitation <i>office and outpatient hospital</i> <i>Coverage is unlimited visits per benefit period.</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Cardiac rehabilitation <i>office and outpatient hospital</i> <i>Coverage is unlimited visits per benefit period.</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Dialysis/Hemodialysis <i>office and outpatient hospital</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy <i>office and outpatient hospital</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Skilled Nursing Care (facility) <i>Coverage for Skilled Nursing is unlimited per benefit period.</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Inpatient Hospice	0% coinsurance after deductible is met	Covered as In-Network
Durable Medical Equipment	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Prosthetic Devices <i>Coverage for wigs is limited to 1 item \$500 after medical treatment per benefit period.</i>	0% coinsurance after deductible is met	30% coinsurance after 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.