

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access PPO

SAA & IU Fellowship

Your Network: Blue Access

Effective: 08/01/2024

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	\$25 copay per visit medical deductible does not apply
Mental Health & Substance Use Disorder Services	\$25 copay per visit medical deductible does not apply
Specialist care	\$35 copay per visit medical deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$0 person / \$0 family	\$700 person / \$2,100 family
Overall Out-of-Pocket Limit	\$2,500 person / \$5,000 family	\$5,000 person / \$10,000 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.

All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit.

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).*

Primary Care (PCP) and Mental Health and Substance Use Disorder Services <i>virtual and office</i>	\$25 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Specialist Care <i>virtual and office</i>	\$35 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
University Health Services (UHS)	\$15 Copayment per visit No Deductible	Not Covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><u>Other Practitioner Visits</u></p> <p>Routine Maternity Care (Prenatal and Postnatal)</p> <p>Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i></p> <p>Manipulation Therapy <i>Coverage is limited to 12 visits per benefit period.</i></p>	<p>\$25 copay per visit medical deductible does not apply</p> <p>\$25 copay per visit medical deductible does not apply</p> <p>\$35 copay per visit medical deductible does not apply</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>
<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 medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p> <p>\$25/\$35 copay per visit medical deductible does not apply[†]</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>
<p>Preventive care / screenings / immunizations</p>	<p>No charge</p>	<p>50% coinsurance after medical deductible is met</p>
<p>Preventive Care for Chronic Conditions <i>per IRS guidelines</i></p>	<p>No charge</p>	<p>50% coinsurance after medical deductible is met</p>
<p><u>Diagnostic Services</u></p> <p>Lab</p> <p>Office</p> <p>Freestanding Lab/Reference Lab</p>	<p>No charge if billed with office visit copay</p> <p>20% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
X-Ray Office - No charge if billed with copay Outpatient Hospital	No Charge 20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met 50% coinsurance after medical deductible is met
Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i> Office Freestanding Radiology Center Outpatient Hospital	20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met 50% coinsurance after medical deductible is met 50% coinsurance after medical deductible is met
<u>Emergency and Urgent Care</u> Urgent Care <i>includes doctor services. Additional charges may apply depending on the care provided.</i> Emergency Room Facility Services <i>Your copay will be waived if admitted.</i> Emergency Room Doctor and Other Services Ambulance	\$50 copay per visit medical deductible does not apply \$150 copay per visit medical deductible does not apply No charge 20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met Covered as In-Network Covered as In-Network Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility Facility Fees	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Doctor Services	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
<p><u>Outpatient Surgery</u></p> <p>Facility Fees</p> <p>Hospital</p> <p>Ambulatory Surgical Center</p> <p>Physician and other services <i>including surgeon fees</i></p> <p>Hospital</p> <p>Ambulatory Surgical Center</p>	<p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>
<p><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u></p> <p>Facility Fees</p> <p>Human Organ and Tissue Transplants <i>Cornea transplants are treated the same as any other illness and subject to the medical benefits.</i></p> <p>Physician and other services <i>including surgeon fees</i></p>	<p>\$200 copay per admission</p> <p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>
<p>Home Health Care <i>Coverage is limited to 100 visits per benefit period.</i></p>	20% coinsurance after medical deductible is met	50% coinsurance after medical 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 including physical, occupational and speech therapies. <i>Coverage for rehabilitative and habilitative Physical Therapy is limited to 60 visits combined per benefit period. Coverage for rehabilitative and habilitative Occupational Therapy is limited to 60 visits combined per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 20 visits combined per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$25/\$35 copay per visit medical deductible does not apply</p> <p>20% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>
<p>Pulmonary rehabilitation <i>Coverage is unlimited visits per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$25/\$35 copay per visit medical deductible does not apply</p> <p>20% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>
<p>Cardiac rehabilitation <i>Coverage is unlimited visits per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$25/\$35 copay per visit medical deductible does not apply</p> <p>20% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>
<p>Dialysis/Hemodialysis</p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$25/\$35 copay deductible does not apply</p> <p>20% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Chemo/Radiation Therapy		
Office	\$25/\$35 copay deductible does not apply	50% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Skilled Nursing Care (facility) <i>Coverage for Skilled Nursing is limited to 90 days per benefit period.</i>	\$200 per admission	50% coinsurance after medical deductible is met
Inpatient Hospice	No charge	No charge
Durable Medical Equipment	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Prosthetic Devices <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable
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: Base Network

Drug List: Select Drugs not included on the Select drug list will not be covered.

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. 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

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use a Non-Network Pharmacy
<i>with special handling, provider coordination or patient education be filled by our designated specialty pharmacy. Drug cost share assistance programs may be available for certain specialty drugs.</i>		
Tier 1 - Typically Generic	\$10 copay per prescription (retail) and \$20 copay per prescription (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand	\$40 copay per prescription (retail) and \$80 copay per prescription (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	\$75 copay per prescription (retail) and \$150 copay per prescription (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 4 – Typically Specialty (brand and generic)	\$150 copay per prescription (30-day supply) Retail and Home Delivery	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<i>This is a brief outline of your vision coverage. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out of pocket limit.</i>		
Children's Vision Essential Health Benefits (up to age 19)		
Vision exam <i>Limited to 1 exam per benefit period.</i>	No charge	Reimbursed Up to \$30
Frames <i>Limited to 1 unit per benefit period.</i>	No charges	Reimbursed Up to \$45
Lenses <i>Limited to 1 unit per benefit period combined with OON Coverage. OON Reimbursement: Single Reimbursed Up to \$25, Bifocal Reimbursed Up to \$40, Trifocal Reimbursed Up to \$55.</i>	No charge	Receives Reimbursement
Elective Contact Lenses <i>Limited to 1 unit per benefit period.</i>	No charge	Reimbursed Up to \$60
Non-Elective Contact Lenses <i>Limited to 1 unit per benefit period.</i>	No charge	Reimbursed Up to \$210

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<i>This is a brief outline of your dental coverage. Only children's dental services count towards your out of pocket limit.</i>		
Children's Dental Essential Health Benefits Diagnostic and preventive <i>Limited to 2 visits per 12 months.</i>	No charge	No charge
Basic services	20% coinsurance deductible does not apply	20% coinsurance deductible does not apply
Major services	50% coinsurance deductible does not apply	50% coinsurance deductible does not apply
Medically Necessary Orthodontia services	50% coinsurance deductible does not apply	50% coinsurance deductible does not apply
Cosmetic Orthodontia services	Not covered	Not covered
Adult Dental	Not covered	Not covered

Notes:

- Dependent Age Limit: to the 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.
- ‡ You will pay the PCP's office visit copay when services are provided in their office.
- Benefit Period – Plan Year

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.

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Questions: (833) 578-4441 or visit us at www.anthem.com

Language Access Services:

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:

Chinese(中文): 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(833) 578-4441。

Farsi (فارسی): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (833) 578-4441 تماس بگیرید.

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (833) 578-4441.

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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Navajo (Diné): Díí naaltsoos biká'ígíí lahgo bína'ídiłkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj'í bee níl hodoonih t'áadoo báąh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih nínízingo koj' hodiilnih (833) 578-4441.

Language Access Services:

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.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਬਾਰੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (833) 578-4441 ਤੇ ਕਾਲ ਕਰੋ।

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Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (833) 578-4441.

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (833) 578-4441.

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.