Your summary of benefits

Anthem® Blue Cross and Blue Shield

Noblesville Schools Effective 9/1/2022

Your Plan: Anthem Blue Access PPO Buy Up

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	$1,500 person / $3,000 family	$3,000 person / $6,000 family
Out-of-Pocket Limit	$3,000 person / $6,000 family	$8,000 person / $16,000 family
The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per person 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 per person deductible or per person out-of-pocket maximum. Your copays, coinsurance and deductible count toward your out of pocket amount(s). In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other.		
Preventive Care / Screening / Immunization	No charge	50% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	50% coinsurance after medical deductible is met
Virtual Care (Telemedicine / Telehealth Visits) **Virtual Visits - Online visits with Doctors who also provide services in person**		
Primary Care (PCP)	$30 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Mental Health and Substance Abuse care	$30 copay per visit medical deductible does not apply	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
Specialist	$60 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Medical Chats and Virtual (Video) Visits for Primary Care from our Online Provider K Health, through its affiliated Provider groups	No charge	
Virtual Visits from Online Provider LiveHealth Online *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*		
Primary Care (PCP) and Mental Health and Substance Abuse	$0 copay per visit medical deductible does not apply	
Specialist Care	$0 copay per visit medical deductible does not apply	
Visits in an Office		
Primary Care (PCP)	$30 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Specialist Care	$60 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Retail Health Clinic	$30 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Manipulation Therapy *Coverage is unlimited visits per benefit period.*	$60 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Other Services in an Office		
Allergy Testing *When Allergy injections are billed separately by network providers, the member is responsible for a $5 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	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
Chemo/Radiation Therapy	$60 copay per visit medical deductible does not apply‡	50% coinsurance after medical deductible is met
Dialysis/Hemodialysis	No charge	50% coinsurance after medical deductible is met
Prescription Drugs *Dispensed in the office*	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Surgery	$60 copay per visit medical deductible does not apply‡	50% coinsurance after medical deductible is met
Diagnostic Services		
Lab		
Office	No charge	50% coinsurance after medical deductible is met
Freestanding Lab/Reference Lab	No charge	50% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
X-Ray		
Office	No charge	50% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	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
Freestanding Radiology Center	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Emergency and Urgent Care		
Urgent Care	$50 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$200 copay per visit medical deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	No Charge	Covered as In-Network
Ambulance	20% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse		
Doctor Office Visit	$30 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Facility Visit		
Facility Fees	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Doctor Services	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Freestanding Surgical Center	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 and Other Services		
Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Freestanding Surgical Center	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	20% coinsurance after medical deductible is met	50% coinsurance after medical 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.*	No charge	50% coinsurance after medical deductible is met
Doctor and other services	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 90 visits per benefit period.*	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Rehabilitation services *Coverage for rehabilitative and habilitative physical therapy and occupational therapy and speech therapy is unlimited visits per benefit period.*		
Office	$60 copay per visit medical 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
Cardiac rehabilitation *Coverage is limited to 36 visits per benefit period.*		
Office	$60 copay per visit medical deductible does not apply	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
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Pulmonary rehabilitation *Coverage is unlimited visits per benefit period.*		
Office	$60 copay per visit medical 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) *Coverage for Skilled Nursing, Outpatient Rehabilitation and Inpatient Rehabilitation facility settings is limited to 150 days combined per benefit period.*	20% coinsurance after medical deductible is met	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 *Coverage for wigs is limited to 1 item after cancer treatment and alopecia diagnosis per benefit period.*	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	$2,500 person $5,000 family	$2,500 person $5,000 family
Prescription Drug Coverage *Cost shares for drugs included on the National drug list appear below. Your plan uses the Base Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies.*		

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use a Non-Network Pharmacy
Home Delivery Pharmacy *Maintenance medication are available through IngenioRx Home Delivery Pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.*		
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy).* *Per 90 day supply (home delivery and Retail 90 pharmacy).*	$10 copay per prescription, deductible does not apply (retail) and $10 copay per prescription, deductible does not apply (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy).* *Per 90 day supply (home delivery and Retail 90 pharmacy).*	$25 copay per prescription, deductible does not apply (retail) and $60 copay per prescription, deductible does not apply (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *Per 30 day supply (retail pharmacy)..* *Per 90 day supply (home delivery and Retail 90 pharmacy).*	$40 copay per prescription, deductible does not apply (retail) and $110 copay per prescription, deductible does not apply (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) *Per 30 day supply (specialty pharmacy).*	$40 copay per prescription, deductible does not apply (retail) and $110 copay per prescription, deductible does not apply (home delivery)	50% coinsurance, deductible does not apply (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.
- ‡ Your cost share will be reduced when services are provided in a PCP's office.

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)

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Language Access Services:

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

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