

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Center Grove Community School Corporation – Effective: 01-01-2026

Your Plan: Anthem Blue Access PPO HSA \$3400 Ded (HDHP)

Your Network: Blue Access

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge after deductible is met
Mental Health & Substance Use Disorder Services	No charge after deductible is met
Specialist care	No charge after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	\$3,400 person / \$6,000 family	\$6,000 person / \$12,000 family
Overall Out-of-Pocket Limit	\$3,400 person / \$6,000 family	\$12,000 person / \$24,000 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 Out-of-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.		
Doctor Visits (virtual and office) <i>You are encouraged to select a Primary Care Physician (PCP). For members up to age 19, visits with In-Network Providers for primary care, and mental health and substance use disorder services are covered at no charge.</i>		
Primary Care (PCP) and Mental Health and Substance Use Disorder Services <i>virtual and office</i> Specialist Provider <i>virtual and office</i>	No charge after deductible is met No charge after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met
<u>Other Practitioner Visits</u> Maternity Doctor services (prenatal/postpartum care and delivery) Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i>	No charge after deductible is met No charge after deductible is met	30% 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 an Out-of-Network Provider
<u>Other Services in an Office</u> Allergy Testing Prescription Drugs <i>Dispensed in the office</i> Surgery	No charge after deductible is met No charge after deductible is met No charge after deductible is met	30% coinsurance after deductible is met 30% 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	Cost share is based on the setting services are received.
<u>Diagnostic Services Lab</u> Office Freestanding Lab/Reference Lab Outpatient Hospital	No charge after deductible is met No charge after deductible is met No charge after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met
<u>Diagnostic Services X-Ray</u> Office Outpatient Hospital	No charge after deductible is met No charge after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met
<u>Diagnostic Services Advanced Diagnostic Imaging</u> <i>for example: MRI, PET and CAT scans</i> Office Freestanding Radiology Center Outpatient Hospital	No charge after deductible is met No charge after deductible is met No charge after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met
<u>Emergency and Urgent Care</u> Urgent Care Emergency Room Facility Services Emergency Room Doctor and Other Services Ambulance <i>Authorized Out-of-Network non-emergency ambulance services are limited to an Anthem maximum payment of \$50,000 per trip. The \$50,000 limit does not apply to air ambulance services.</i>	No charge after deductible is met No charge after deductible is met No charge after deductible is met No charge after deductible is met	30% coinsurance after deductible is met Covered as In-Network Covered as In-Network Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<u>Outpatient Mental Health and Substance Use Disorder Services at a Facility</u> Facility Fees Doctor Services	 No charge after deductible is met No charge 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 Physician and other services <i>including surgeon fees</i> Hospital Ambulatory Surgical Center	 No charge after deductible is met No charge after deductible is met No charge after deductible is met No charge after deductible is met No charge 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 30% coinsurance after deductible is met
<u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u> Facility Fees Human Organ and Tissue Transplants <i>Cornea transplants are treated as medical procedures, with benefits and cost sharing determined by the setting in which the services are received.</i> Physician and other services <i>including surgeon fees</i>	 No charge after deductible is met No charge after deductible is met No charge after deductible is met	 30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met
<u>Home Health Care</u> <i>Coverage is unlimited visits per benefit period.</i>	No charge after deductible is met	30% coinsurance after deductible is met
<u>Therapy Services</u> Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies.</i> <i>Coverage for physical therapy is unlimited visits per benefit period.</i> <i>Coverage for occupational therapy is unlimited visits per benefit period.</i> <i>Coverage for speech therapy is unlimited visits per benefit period.</i> Office Outpatient Hospital Manipulation Therapy <i>office and outpatient hospital</i> <i>Coverage is unlimited visits per benefit period.</i>	 No charge after deductible is met No charge after deductible is met No charge after deductible is met	 30% coinsurance after deductible is met 30% 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>	No charge 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 an Out-of-Network Provider
Cardiac rehabilitation office and outpatient hospital <i>Coverage is limited to 36 visits per benefit period.</i>	No charge after deductible is met	30% coinsurance after deductible is met
Dialysis/Hemodialysis office and outpatient hospital	No charge after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy office and outpatient hospital	No charge after deductible is met	30% coinsurance after deductible is met
Skilled Nursing Care (facility) <i>Coverage for Skilled Nursing is unlimited days per benefit period.</i>	No charge after deductible is met	30% coinsurance after deductible is met
Inpatient Hospice	No charge after deductible is met	Covered as In-Network
<u>Additional Services, Equipment and Devices</u>		
Durable Medical Equipment	No charge after deductible is met	30% coinsurance after deductible is met
Prosthetic Devices	No charge after deductible is met	30% coinsurance after deductible is met
Wigs <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	No charge after deductible is met	30% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with Out-of-Network medical deductible
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Out-of-Network medical out-of-pocket limit
Prescription Drug Coverage Network: Base Network Drug List: National <i>If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.</i>		
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 our 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. Specialty Pharmacy 30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs 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.		
Tier 1 - Typically Generic	0% coinsurance after deductible is met (retail and home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Tier 2 - Typically Preferred Brand	0% coinsurance after deductible is met (retail and home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	0% coinsurance after deductible is met (retail and home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	0% coinsurance after deductible is met (retail and home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-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 exam (up to age 19) <i>Limited to 1 exam per benefit period.</i>	No charge	\$0 copayment up to plan's Maximum Allowed Amount
Adult Vision exam (age 19 and older) <i>Limited to 1 exam per benefit period.</i>	No charge	Reimbursed Up to \$42

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 Out-of-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 an Out-of-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.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
- The representations of benefits in this document are subject to Indiana Department of Insurance (IN DOI) approval and are subject to change.

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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