

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

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	\$30 copay per visit medical deductible does not apply
Mental Health & Substance Use Disorder Services	\$30 copay per visit medical deductible does not apply
Specialist care	\$50 copay per visit medical deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	\$1,000 person / \$2,000 family	\$2,000 person / \$4,000 family
Overall Out-of-Pocket Limit <i>The out-of-pocket cost you pay for prescription drugs obtained at a pharmacy will apply to a separate Pharmacy Out-of-Pocket Limit. See the Covered Prescription Drug Benefits section.</i>	\$2,000 person / \$4,000 family	\$4,000 person / \$8,000 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).</i>		
Primary Care (PCP) and Mental Health and Substance Use Disorder Services <i>virtual and office</i>	\$30 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Specialist Provider <i>virtual and office</i>	\$50 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Other Practitioner Visits		
Maternity Doctor services (prenatal/postpartum care and delivery) the 1st visit will apply to the PCP copay and after the initial visit the benefit will apply deductible/coinsurance	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i>	\$30 copay per visit medical deductible does not apply	40% coinsurance after medical 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 <i>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.</i> Prescription Drugs <i>Dispensed in the office</i>	20% coinsurance after medical deductible is met No charge	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
Surgery	\$50 copay per visit medical deductible does not apply [†]	40% coinsurance after medical deductible is met
Preventive care / screenings / immunizations	No charge	40% coinsurance after medical 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	No charge	40% coinsurance after medical deductible is met
Freestanding Lab/Reference Lab	No charge	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<u>Diagnostic Services X-Ray</u>		
Office	No charge	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<u>Diagnostic Services Advanced Diagnostic Imaging</u> <i>for example: MRI, PET and CAT scans</i>		
Office	No charge	40% coinsurance after medical deductible is met
Freestanding Radiology Center	No charge	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Hospital	No charge	40% coinsurance after medical deductible is met
<u>Emergency and Urgent Care</u> Urgent Care includes doctor services. Additional charges may apply depending on the care provided. Emergency Room Facility Services Your copay will be waived if admitted. Emergency Room Doctor and Other Services Ambulance 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.	\$75 copay per visit medical deductible does not apply \$300 copay per visit medical deductible does not apply No charge 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met Covered as In-Network Covered as In-Network Covered as In-Network
<u>Outpatient Mental Health and Substance Use Disorder Services at a Facility</u> Facility Fees Doctor Services	20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
<u>Outpatient Surgery</u> Facility Fees Hospital Ambulatory Surgical Center Physician and other services including surgeon fees Hospital Ambulatory Surgical Center	20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<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 including surgeon fees	20% coinsurance after medical deductible is met No charge 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 50% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
<u>Home Health Care</u> <i>Coverage is unlimited per benefit period.</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical 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>Coverage is limited to 12 visits per benefit period.</i> Office Outpatient Hospital	\$50 copay per visit medical deductible does not apply 20% coinsurance after medical deductible is met \$50 copay per visit medical deductible does not apply 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
<u>Pulmonary rehabilitation</u> <i>Coverage is limited to 20 visits per benefit period.</i> Office Outpatient Hospital	\$50 copay per visit medical deductible does not apply 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
Cardiac rehabilitation		

Covered Medical Benefits		Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<i>Coverage is limited to 36 visits per benefit period.</i>			
Office		\$50 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Outpatient Hospital		20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Dialysis/Hemodialysis			
Office		No charge	40% coinsurance after medical deductible is met
Outpatient Hospital		20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Chemo/Radiation Therapy			
Office		\$50 copay per visit medical deductible does not apply ⁺	40% coinsurance after medical deductible is met
Outpatient Hospital		20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Skilled Nursing Care (facility) <i>Coverage for Skilled Nursing is unlimited days per benefit period.</i>		20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Inpatient Hospice		No charge	No charge
<u>Additional Services, Equipment and Devices</u>			
Durable Medical Equipment		20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prosthetic Devices		20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Wigs <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>		20% coinsurance after medical deductible is met	40% coinsurance after medical 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	Not applicable	Not applicable

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Out-of-Pocket Limit	\$4000 person / \$8000 family	Unlimited
Prescription Drug Coverage Network: Base Network Drug List: National If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.		
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.		
Tier 1 - Typically Generic	\$25 copay per prescription (retail) and \$50 copay per prescription (home delivery)	Greater of \$50 or 50% coinsurance deductible does not apply (retail) and Not covered (home delivery)
Tier 2 - Typically Preferred Brand	\$35 copay per prescription (retail) and \$70 copay per prescription (home delivery)	Greater of \$50 or 50% coinsurance deductible does not apply (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	\$60 copay per prescription (retail) and \$120 copay per prescription (home delivery)	Greater of \$50 or 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 an Out-of-Network Provider
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.		
Children's Vision exam (up to age 19) Limited to 1 exam per benefit period.	No charge	\$0 copayment up to plan's Maximum Allowed Amount
Adult Vision exam (age 19 and older) Limited to 1 exam per benefit period.	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.
- ‡ You will pay your PCP or Specialist office visit copay for certain services provided in their office.
- 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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