

# Your summary of benefits

Anthem® BlueCross and BlueShield  
 Your Plan: Anthem Blue Access PPO  
 Your Network: Blue Access

Vanderburgh County Employees  
 Effective 1/1/2020

*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.*

*This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.*

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b> <i>See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.</i>	\$500 person / \$1,000 family	\$1,000 person / \$2,000 family
<b>Out-of-Pocket Limit</b> <i>When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.</i>	\$1,500 person / \$3,000 family	\$3,000 person / \$6,000 family
<b>Preventive care/screening/immunization</b> <i>In-network preventive care is not subject to deductible, if your plan has a deductible.</i>	No charge	40% coinsurance after deductible is met
<b>Doctor Home and Office Services</b>  <b>Primary Care Visit to treat an injury or illness</b> <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>	\$50 copay per visit deductible does not apply	40% coinsurance after deductible is met
<b>Specialist Care Visit</b> <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>	\$60 copay per visit deductible does not apply	40% coinsurance after deductible is met

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Prenatal and Post-natal Care</b> <i>In-Network preventive prenatal services are covered at 100%.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Other Practitioner Visits:</b>  Retail Health Clinic  Preferred On-line Visit <i>Includes Mental/Behavioral Health and Substance Abuse</i>  Other Participating Provider On-line Visit <i>Includes Mental/Behavioral Health and Substance Abuse</i>  Manipulation Therapy <i>Coverage is limited to 30 visits per benefit period. Limit is combined In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits.</i>	\$50 copay per visit deductible does not apply  \$10 copay per visit deductible does not apply  \$50 copay per visit deductible does not apply  \$20 copay per visit deductible does not apply	40% coinsurance after deductible is met  40% coinsurance after deductible is met  40% coinsurance after deductible is met  40% coinsurance after deductible is met
<b>Other Services in an Office:</b>  Allergy Testing  Chemo/Radiation Therapy Performed by a Primary Care Physician  Chemo/Radiation Therapy Performed by a Specialist  Dialysis/Hemodialysis  Prescription Drugs <i>For the drugs itself dispensed in the office through infusion/injection.</i>	20% coinsurance after deductible is met  \$50 copay per visit deductible does not apply  \$60 copay per visit deductible does not apply  20% coinsurance after deductible is met  20% coinsurance after deductible is met	40% coinsurance after deductible is met  40% coinsurance after deductible is met  40% coinsurance after deductible is met  40% coinsurance after deductible is met

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<p><b>Diagnostic Services</b></p> <p><b>Lab:</b></p> <ul style="list-style-type: none"> <li>Office</li> <li>Freestanding Lab/Reference Lab</li> <li>Outpatient Hospital</li> </ul>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b>X-Ray:</b></p> <ul style="list-style-type: none"> <li>Office</li> <li>Outpatient Hospital</li> </ul>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b>Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):</b></p> <ul style="list-style-type: none"> <li>Office</li> <li>Freestanding Radiology Center</li> <li>Outpatient Hospital</li> </ul>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>Emergency and Urgent Care</b></p> <p><b>Urgent Care (Office Setting)</b>  <i>Member cost share for Allergy injections billed separately is \$5 copay. If billed with an Urgent Care Facility charge, it will be covered under the UC copayment, there is no additional cost to the member for the injection.</i></p> <p><b>Urgent care(Facility Setting)</b></p> <p><b>Urgent Care: Facility fees</b></p> <p><b>Urgent Care: Doctor and other services</b></p>	<p>\$75 copay per visit deductible does not apply</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b>Emergency Room Facility Services</b>  <i>Copay waived if admitted.</i></p> <p><b>Emergency Room Doctor and Other Services</b></p>	<p>\$500 copay per visit deductible does not apply</p> <p>20% coinsurance deductible does not apply</p>	<p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p><b>Ambulance (Air, Ground, and Water)</b>  <i>Non-emergency non-network Ambulance Services are limited to \$50,000 per occurrence.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>Covered as In-Network</p>
<p><b>Outpatient Mental/Behavioral Health and Substance Abuse</b></p> <p><b>Doctor Office Visit</b></p> <p><b>Facility visit:</b></p> <p>    Facility Fees</p> <p>    Doctor Services</p>	<p>\$20 copay per visit deductible does not apply</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>Outpatient Surgery</b></p> <p><b>Facility Fees:</b></p> <p>Hospital</p> <p>Freestanding Surgical Center</p> <p><b>Doctor and Other Services:</b></p> <p>Hospital</p> <p>Freestanding Surgical Center</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b>Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)</b></p> <p><b>Facility fees (for example, room &amp; board)</b>  <i>Coverage for Inpatient Physical Medicine and Rehabilitation including day rehabilitation is limited to 60 days per benefit period. Limit is combined In-Network and Non-Network.</i></p> <p><b>Human Organ and Tissue Transplants</b>  <i>Acquisition and transplant procedures, collection and storage. Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.</i></p> <p><b>Doctor and other services</b></p>	<p>20% coinsurance after deductible is met</p> <p>No charge</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>Recovery &amp; Rehabilitation</b></p> <p><b>Home Health Care</b>  <i>Coverage is limited to 100 visits per benefit period. Limit is combined In-Network and Non-Network. Private Duty Nursing limited to 82 visits/ Calendar Year and, 164 visits/ lifetime</i></p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p><b>Rehabilitation services (for example, physical/speech/occupational therapy):</b></p> <p><b>Office</b>  <i>Limit is combined for rehabilitative and habilitative services. Coverage for Occupational Therapy is limited to 45 visits per benefit period, Physical Therapy is limited to 45 visits per benefit period and Speech Therapy is limited to 45 visits per benefit period. Visit limits are combined both across outpatient and other professional visits. Limit is combined for In-Network and Non-Network.</i></p> <p><b>Outpatient Hospital</b>  <i>Limit is combined for rehabilitative and habilitative services. Coverage for Occupational Therapy is limited to 45 visits per benefit period, Physical Therapy is limited to 45 visits per benefit period and Speech Therapy is limited to 45 visits per benefit period. Visit limits are combined both across outpatient and other professional visits. Limit is combined for In-Network and Non-Network.</i></p>	<p>\$20 copay per visit deductible does not apply</p> <p>20% coinsurance after deductible is met</p>	40% coinsurance after deductible is met
<p><b>Cardiac rehabilitation</b></p> <p><b>Office Setting</b>  <i>Coverage is limited to 36 visits per benefit period. Limit is combined In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits.</i></p> <p><b>Outpatient Hospital</b>  <i>Coverage is limited to 36 visits per benefit period. Limit is combined In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits.</i></p>	<p>\$20 copay per visit deductible does not apply</p> <p>20% coinsurance after deductible is met</p>	40% coinsurance after deductible is met
<p><b>Pulmonary rehabilitation</b></p> <p><b>Office</b></p>	\$20 copay per visit deductible does not apply	40% coinsurance after deductible is met

# Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><i>Coverage is limited to 24 visits per benefit period. Limit is combined In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits.</i></p> <p><b>Outpatient Hospital</b>  <i>Coverage is limited to 24 visits per benefit period. Limit is combined In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits.</i></p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p><b>Skilled Nursing Care (in a facility)</b>  <i>Skilled Nursing is limited to 90 days per benefit period. Limit is combined In-Network and Non-Network. Benefit includes coverage for Outpatient Rehabilitation program.</i></p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p><b>Hospice</b></p>	No charge	No charge
<p><b>Durable Medical Equipment</b></p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p><b>Prosthetic Devices</b></p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met

# Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Pharmacy Deductible</b>	Not applicable	Not applicable
<b>Pharmacy Out of Pocket</b>	Combined with medical out of pocket maximum	Combined with medical out of pocket maximum
<b>Prescription Drug Coverage</b> <i>National Drug List</i> <i>A 90 day supply is available at most retail pharmacies.</i>		
<b>Tier 1 - Typically Generic</b> <i>Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.</i>	\$25 copay per prescription, deductible does not apply (retail) and \$25 copay per prescription, deductible does not apply (home delivery)	50% coinsurance, min \$50 (retail) and Not covered (home delivery)
<b>Tier 2 – Typically Preferred Brand</b> <i>Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.</i>	\$35 copay per prescription, deductible does not apply (retail) and \$88 copay per prescription, deductible does not apply (home delivery)	50% coinsurance, min \$50 (retail) and Not covered (home delivery)
<b>Tier 3 - Typically Non-Preferred Brand</b> <i>Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.</i>	\$50 copay per prescription, deductible does not apply (retail) and \$150 copay per prescription, deductible does not	50% coinsurance (retail) and Not covered (home delivery)



# Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
	apply (home delivery)	
<p><b>Tier 4 - Typically Specialty (brand and generic)</b>  <i>Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program).</i></p>	Not applicable	Not applicable

# Your summary of benefits

## Notes:

- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual 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 individual deductible and individual out-of-pocket maximum.
- Network and Non-network deductibles, copayments, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- Dependent age: to end of the month in which the child attains age 26.
- 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.
- Certain diabetic and asthmatic supplies are available at Network pharmacies, diabetic test strips paid same as any other drug.
- Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.
- Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are covered.
- Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.
- 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.
- All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum.
- If office visit is a coinsurance, the coinsurance also applies to allergy injections.
- No Copayment or Coinsurance applies to certain diabetic and asthmatic supplies when you get them from an In-Network Pharmacy. These supplies are covered as Medical Supplies and Durable Medical Equipment if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance. Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.
- Hospital stay for Maternity Coverage will not be limited to less than 48 hours for a vaginal delivery or 96 hours for a caesarean section.
- PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan.
- Benefits are limited to abortions due to an act of rape or incest, to avert death, or a substantial and irreversible impairment of a major bodily function.
- Urgent Care Facility Copay exclude certain diagnostic test such as MRAs, MRIs, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, Allergy Testing, and Pharmaceutical injection and drugs.

# Your summary of benefits

**This benefit overview is for illustrative purposes and some content may be pending Indiana Department of Insurance approval.**

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date

## 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 هزینه‌ای 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.

**Italian (Italiano):** In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (833) 578-4441.

**Japanese (日本語):** この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(833) 578-4441 にお電話ください。

## Language Access Services:

**Korean (한국어):** 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(833) 578-4441로 문의하십시오.

**Navajo (Diné):** Dii naaltsoos biká'ígíí lahgo bina'idiikidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj̄ bee nił hodoonih t'áadoo bááh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih ninizingo koj̄' hodiilnih (833) 578-4441.

**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 ਦੁਬਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (833) 578-4441 ਤੇ ਕਾਲ ਕਰੋ।

**Russian (Русский):** если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (833) 578-4441.

**Spanish (Español):** Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (833) 578-4441.

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**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>.