Your summary of benefits

Anthem®

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access PPO | Plan A | Michigan City Area Schools – Teachers

Your Network: Blue Access | Effective: 07/01/2022

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$200 person / $600 family	$300 person / $800 family
Out-of-Pocket Limit	$700 person / $1,600 family	$2,300 person / $4,800 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	35% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	35% 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)	$10 copay per visit medical deductible does not apply	35% coinsurance after medical deductible is met
Mental Health and Substance Abuse care	$10 copay per visit medical deductible does not apply	35% 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	$10 copay per visit medical deductible does not apply	35% 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	$10 copay per visit medical deductible does not apply	
Specialist Care	$10 copay per visit medical deductible does not apply	
Visits in an Office		
Primary Care (PCP)	$10 copay per visit medical deductible does not apply	35% coinsurance after medical deductible is met
Specialist Care	$10 copay per visit medical deductible does not apply	35% coinsurance after medical deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	15% coinsurance after medical deductible is met	35% coinsurance after medical deductible is met
Retail Health Clinic	$10 copay per visit medical deductible does not apply	35% coinsurance after medical deductible is met
Manipulation Therapy *Coverage is limited to 24 visits per benefit period.*	$10 copay per visit medical deductible does not apply	35% 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 $0 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	No charge	35% 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	$10 copay per visit medical deductible does not apply‡	35% coinsurance after medical deductible is met
Dialysis/Hemodialysis	No charge	35% coinsurance after medical deductible is met
Prescription Drugs *Dispensed in the office*	No charge	35% coinsurance after medical deductible is met
Surgery	$10 copay per visit medical deductible does not apply‡	35% coinsurance after medical deductible is met
Diagnostic Services		
Lab		
Office	No charge	35% coinsurance after medical deductible is met
Freestanding Lab/Reference Lab	No charge	35% coinsurance after medical deductible is met
Outpatient Hospital	15% coinsurance after medical deductible is met	35% coinsurance after medical deductible is met
X-Ray		
Office	No charge	35% coinsurance after medical deductible is met
Outpatient Hospital	15% coinsurance after medical deductible is met	35% coinsurance after medical deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	No charge	35% 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	15% coinsurance after medical deductible is met	35% coinsurance after medical deductible is met
Outpatient Hospital	15% coinsurance after medical deductible is met	35% coinsurance after medical deductible is met
Emergency and Urgent Care		
Urgent Care	$10 copay per visit medical deductible does not apply	35% coinsurance after medical deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$50 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	15% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse		
Doctor Office Visit	$10 copay per visit medical deductible does not apply	35% coinsurance after medical deductible is met
Facility Visit		
Facility Fees	15% coinsurance after medical deductible is met	35% coinsurance after medical deductible is met
Doctor Services	15% coinsurance after medical deductible is met	35% coinsurance after medical deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	15% coinsurance after medical deductible is met	35% coinsurance after medical deductible is met
Freestanding Surgical Center	15% coinsurance after medical deductible is met	35% 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	15% coinsurance after medical deductible is met	35% coinsurance after medical deductible is met
Freestanding Surgical Center	15% coinsurance after medical deductible is met	35% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	15% coinsurance after medical deductible is met	35% 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	10% coinsurance after medical deductible is met
Doctor and other services	15% coinsurance after medical deductible is met	35% coinsurance after medical deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is unlimited visits per benefit period.*	20% coinsurance after medical deductible is met	35% coinsurance after medical deductible is met
Rehabilitation services *Coverage for rehabilitative and habilitative physical therapy is limited to 45 visits per benefit period. Occupational therapy is unlimited visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is unlimited visits per benefit period.*		
Office	$10 copay per visit medical deductible does not apply	35% coinsurance after medical deductible is met
Outpatient Hospital	15% coinsurance after medical deductible is met	35% coinsurance after medical deductible is met
Cardiac rehabilitation *Coverage is unlimited visits per benefit period.*		
Office	$10 copay per visit medical deductible does not apply	35% 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	15% coinsurance after medical deductible is met	35% coinsurance after medical deductible is met
Pulmonary rehabilitation *Coverage is unlimited visits per benefit period.*		
Office	$10 copay per visit medical deductible does not apply	35% coinsurance after medical deductible is met
Outpatient Hospital	15% coinsurance after medical deductible is met	35% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Coverage for Skilled Nursing is unlimited days per benefit period.*	15% coinsurance after medical deductible is met	35% coinsurance after medical deductible is met
Inpatient Hospice	15% coinsurance after medical deductible is met	15% coinsurance after medical deductible is met
Durable Medical Equipment	15% coinsurance after medical deductible is met	35% coinsurance after medical deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	15% coinsurance after medical deductible is met	35% 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 *Cost shares for drugs included on the Essential drug list appear below. Drugs not included on the Essential drug list will not be covered. 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 34 day supply (retail pharmacy and Retail 90 pharmacy).* *Per 90 day supply (home delivery).*	$10 copay per prescription, deductible does not apply (retail) and $20 copay per prescription, deductible does not apply (home delivery)	Greater of $40 or 50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *Per 34 day supply (retail pharmacy and Retail 90 pharmacy).* *Per 90 day supply (home delivery).*	$20 copay per prescription, deductible does not apply (retail) and $40 copay per prescription, deductible does not apply (home delivery)	Greater of $40 or 50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *Per 34 day supply (retail pharmacy and Retail 90 pharmacy).* *Per 90 day supply (home delivery).*	$40 copay per prescription, deductible does not apply (retail) and $60 copay per prescription, deductible does not apply (home delivery)	Greater of $40 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 a Non-Network Provider
This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.		
Children's Vision (up to age 19) **Child Vision Deductible**	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Adult Vision (age 19 and older) **Adult Vision Deductible**	$0 person	$0 person
Vision exam	No charge	Reimbursed Up to $42

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Limited to 1 exam per benefit period.		

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

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(TTY/TDD: 711)

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Language Access Services:

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