

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Dental Practice Consortium Inc – Effective: 01-01-2025

Your Plan: Anthem Blue Access PPO HSA \$6450 Ded

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	Khealth: Not covered LHO: No charge after deductible is met
Mental Health & Substance Use Disorder Services	Khealth: Not covered LHO: 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	\$6,450 person / \$12,900 family	\$12,900 person / \$25,800 family
Overall Out-of-Pocket Limit	\$6,450 person / \$12,900 family	\$12,900 person / \$25,800 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) *You are encouraged to select a Primary Care Physician (PCP).*

Primary Care (PCP) and Mental Health and Substance Use Disorder Services <i>virtual and office</i>	No charge after deductible is met	30% coinsurance after deductible is met
Specialist Care <i>virtual and office</i>	No charge after deductible is met	30% coinsurance after deductible is met
<u>Other Practitioner Visits</u>		
Maternity Doctor services (prenatal/postnatal care and delivery)	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
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	30% coinsurance after deductible is met
Manipulation Therapy <i>Coverage is limited to 12 visits per benefit period.</i>	No charge after deductible is met	30% coinsurance after deductible is met
<u>Other Services in an Office</u>		
Allergy Testing	No charge after deductible is met	30% coinsurance after deductible is met
Prescription Drugs <i>Dispensed in the office</i>	No charge after deductible is met	30% coinsurance after deductible is met
Surgery	No charge 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	30% coinsurance after deductible is met
<u>Diagnostic Services</u>		
Lab		
Office	No charge after deductible is met	30% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	No charge after deductible is met	30% coinsurance after deductible is met
X-Ray		
Office	No charge after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	No charge after deductible is met	30% coinsurance after deductible is met
Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i>		
Office	No charge after deductible is met	30% coinsurance after deductible is met
Freestanding Radiology Center	No charge after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	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
<u>Emergency and Urgent Care</u> Urgent Care Emergency Room Facility Services Emergency Room Doctor and Other Services Ambulance <i>Non-emergency Out-of-Network 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 No charge after deductible is met	30% coinsurance after 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	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 including surgeon fees 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
<u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u> Facility Fees Human Organ and Tissue Transplants <i>Cornea transplants are treated the same as any other illness and subject to the medical benefits.</i> Physician and other services including surgeon fees	 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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Home Health Care <i>Coverage is limited to 90 visits per benefit period.</i>	No charge after deductible is met	30% coinsurance after deductible is met
Rehabilitation and Habilitation services including physical, occupational and speech therapies. <i>Coverage for physical therapy is limited to 20 visits per benefit period.</i> <i>Coverage for occupational therapy is limited to 20 visits per benefit period.</i> <i>Coverage for speech therapy is limited to 20 visits per benefit period.</i> 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
Pulmonary rehabilitation office and outpatient hospital <i>Coverage is limited to 20 visits per benefit period.</i>	No charge after deductible is met	30% coinsurance after deductible is met
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 limited to 90 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
Durable Medical Equipment	No charge after deductible is met	30% coinsurance after deductible is met
Prosthetic Devices <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

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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