

Your summary of benefits



Anthem® Blue Cross and Blue Shield

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

Your Plan: Anthem Blue Access PPO \$500 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: \$5 copay per visit medical deductible does not apply
Mental Health & Substance Use Disorder Services	KHealth: Not covered. LHO: \$5 copay per visit medical deductible does not apply
Specialist care	\$5 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	\$500 person / \$1,500 family	\$1,000 person / \$3,000 family
Overall Out-of-Pocket Limit	\$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) *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>	\$25 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Specialist Care <i>virtual and office</i>	\$25 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 Practitioner Visits</u>		
Maternity Doctor services (prenatal/postnatal care and delivery)	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>	\$25 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Manipulation Therapy <i>Coverage is limited to 12 visits per benefit period.</i>	\$25 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
<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>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prescription Drugs <i>Dispensed in the office</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Surgery	\$25 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	40% coinsurance after medical deductible is met
<u>Diagnostic Services</u>		
Lab		
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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
X-Ray Office Outpatient Hospital	No charge 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i> Office Freestanding Radiology Center Outpatient Hospital	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
<u>Emergency and Urgent Care</u> Urgent Care <i>includes doctor services. Additional charges may apply depending on the care provided.</i> Emergency Room Facility Services <i>Your copay will be waived if admitted.</i> 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>	\$75 copay per visit medical deductible does not apply \$200 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
Outpatient Mental Health and Substance Use Disorder Services at a Facility 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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<u>Outpatient Surgery</u> Facility Fees Hospital Ambulatory Surgical Center Physician and other services <i>including surgeon fees</i> 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
<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 <i>including surgeon fees</i>	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
Home Health Care <i>Coverage is limited to 90 visits per benefit period.</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies.</i> <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	 \$25 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
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Pulmonary rehabilitation <i>Coverage is limited to 20 visits per benefit period.</i> Office Outpatient Hospital	 \$25 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 <i>Coverage is limited to 36 visits per benefit period.</i> Office Outpatient Hospital	 \$25 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
Dialysis/Hemodialysis Office Outpatient Hospital	 No charge 20% coinsurance after medical deductible is met	 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
Chemo/Radiation Therapy Office Outpatient Hospital	 \$25 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
Skilled Nursing Care (facility) <i>Coverage for Skilled Nursing is limited to 90 days per benefit period.</i>	20% 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
Inpatient Hospice	No charge	No charge
Durable Medical Equipment	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prosthetic Devices <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

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 the PCP's office visit copay when services are 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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