Hoosier School Benefit Trust: Blue Access (PPO) Plan 3

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2017 – 12/31/2017
Coverage for: Individual + Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at https://eoc.anthem.com/eocdps/aso or by calling (800) 345-2460.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,500** single / **$3,000** family for In-Network Providers. Does not apply to Primary Care visit, Preventive care, and Specialist visit. **$3,000** single / **$6,000** family for Out-of-Network Providers. In-Network Providers and Non-Network Providers deductibles are separate and do not count towards each other.	You must pay all costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes; **$6,000** single / **$10,000** family for In-Network Providers. **$12,000** single / **$20,000** family for Out-of-Network Providers. In-Network Providers and Non-Network Providers Out of Pocket are separate and do not count towards each other.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Non-Network Transplant Services, Premiums, Balance-Billed charges, and Health Care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.

Questions: Call (800) 345-2460 or visit us at www.anthem.com
IN/L/A/HOOSCHLBENTRUST:BAPN3-PPO/NA/NA/01-17
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Important Questions	Answers	Why this Matters:
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes, Blue Access. For a list of Network providers, see www.anthem.com or call **(800) 345-2460**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No; you do not need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 8. See your policy or plan document for additional information about **excluded services.**

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **Network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost if You Use an Network Provider	Your Cost if You Use an Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 copay per visit	50% coinsurance	--------none--------
	Specialist visit	$60 copay per visit	50% coinsurance	--------none--------
	Other practitioner office visit	Manipulative Therapy $30 copay per visit Acupuncture Not covered	Manipulative Therapy 50% coinsurance Acupuncture Not covered	Manipulative Therapy Coverage for In-Network Providers and Non-Network Providers combined is limited to 24 visits per benefit period. Acupuncture --------none--------
	Preventive care/screening/immunization	No cost share	50% coinsurance	--------none--------
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office No cost share X-Ray – Office No cost share	Lab – Office 50% coinsurance X-Ray – Office 50% coinsurance	Lab – Office Costs may vary by site of service. X-Ray – Office Costs may vary by site of service.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	--------none--------

Common Medical Event	Services You May Need	Your Cost if You Use an Network Provider	Your Cost if You Use an Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.anthem.com/pharmacyinformation/	Tier 1 - Typically Generic	20% coinsurance (retail only) and $15 copay per prescription (home delivery only)	50% coinsurance (retail only)	Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program) Home delivery is not covered for Non-Network Providers. (Includes diabetic test strip).
	Tier 2 - Typically Preferred / Brand	$25 copay per prescription or 20% coinsurance, whichever is greater (retail only) and $35 copay per prescription (home delivery only)	50% coinsurance (retail only)	Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program) Home delivery is not covered for Non-Network Providers. Member may be responsible for additional cost when not selecting the available generic drug. (Includes diabetic test strip).
	Tier 3 - Typically Non-Preferred	$40 copay per prescription or 35% coinsurance, whichever is greater (retail only) and $100 copay per	50% coinsurance (retail only)	Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program) Home

Common Medical Event	Services You May Need	Your Cost if You Use an Network Provider	Your Cost if You Use an Non-Network Provider	Limitations & Exceptions
		prescription (home delivery only)		delivery is not covered for Non-Network Providers. Member may be responsible for additional cost when not selecting the available generic drug. (Includes diabetic test strip).
	Tier 4 - Typically Specialty Drugs	30% coinsurance up to $200 per prescription (retail only) This has a 3 time fill at retail, then home delivery is mandatory and 30% coinsurance up to $200 per prescription (home delivery only)	50% coinsurance (retail only)	Home delivery is not covered for Non-Network Providers. Member may be responsible for additional cost when not selecting the available generic drug. Specialty medications are limited to a 30 day supply regardless of whether they are retail or home delivery. Specialty medications must be obtained via our specialty Pharmacy network in order to receive network level benefits. (Includes diabetic test strip).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	--------none--------
	Physician/surgeon fees	20% coinsurance	50% coinsurance	--------none--------
If you need immediate medical attention	Emergency room services	$175 copay per visit	Covered as In-	Copay waived if

Common Medical Event	Services You May Need	Your Cost if You Use an Network Provider	Your Cost if You Use an Non-Network Provider	Limitations & Exceptions
			Network	admitted.
	Emergency medical transportation	20% coinsurance	Covered as In-Network	--------none--------
	Urgent care	$100 copay per visit	50% coinsurance	There may be other levels of cost share that are contingent on how services are provided.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	--------none--------
	Physician/surgeon fee	20% coinsurance	50% coinsurance	--------none--------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit $40 copay per visit Mental/Behavioral Health Facility Visit - Facility Charges 20% coinsurance	Mental/Behavioral Health Office Visit 50% coinsurance Mental/Behavioral Health Facility Visit - Facility Charges 50% coinsurance	Mental/Behavioral Health Office Visit --------none-------- Mental/Behavioral Health Facility Visit - Facility Charges --------none--------
	Mental/Behavioral health inpatient services	20% coinsurance	50% coinsurance	--------none--------
	Substance use disorder outpatient services	Substance Use Office Visit $40 copay per visit Substance Use Facility Visit - Facility Charges 20% coinsurance	Substance Use Office Visit 50% coinsurance Substance Use Facility Visit - Facility Charges 50% coinsurance	Substance Use Office Visit --------none-------- Substance Use Facility Visit - Facility Charges --------none--------
	Substance use disorder inpatient services	20% coinsurance	50% coinsurance	--------none--------
If you are pregnant	Prenatal and postnatal care	20% coinsurance	50% coinsurance	--------none--------
	Delivery and all inpatient services	20% coinsurance	50% coinsurance	--------none--------
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Coverage for In-Network Providers and Non-Network

Common Medical Event	Services You May Need	Your Cost if You Use an Network Provider	Your Cost if You Use an Non-Network Provider	Limitations & Exceptions
				Providers combined is limited to 100 visits per benefit period.
	Rehabilitation services	$40 copay per visit	50% coinsurance	Costs may vary by site of service.
	Habilitation services	$40 copay per visit	50% coinsurance	Costs may vary by site of service.
	Skilled nursing care	20% coinsurance	50% coinsurance	Coverage for In-Network Providers and Non-Network Providers combined is limited to 60 days limit per benefit period.
	Durable medical equipment	20% coinsurance	50% coinsurance	--------none--------
	Hospice service	20% coinsurance	50% coinsurance	--------none--------
If your child needs dental or eye care	Eye exam	Not covered	Not covered	--------none--------
	Glasses	Not covered	Not covered	--------none--------
	Dental check-up	Not covered	Not covered	--------none--------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Infertility treatment
- Long- term care
- Routine eye care (adult)
- Routine foot care unless you have been diagnosed with diabetes.
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery for morbid obesity only.
- Chiropractic care
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide
- Private-duty nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at (800) 345-2460. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

ATTN: Grievances and Appeals
P.O. Box 105568
Atlanta GA 30348-5568

Department of Labor, Employee
Benefits Security Administration
(866) 444-EBSA (3272)
www.dol.gov/ebsa/healthreform

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy <u>does</u> provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage _____ meet the minimum value standard for the benefits it provides.**

Language Access Services:

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'alníhí ya sidáhí bich'į naabídíiłkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About These Coverage Examples:

These examples show how this plan might cover
medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,840
- **Patient pays** $2,700

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,500
Copays	$0
Coinsurance	$1,050
Limits or exclusions	$150
Total	$2,700

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,980
- **Patient pays** $2,420

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,500
Copays	$200
Coinsurance	$640
Limits or exclusions	$80
Total	$2,420

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co payments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call (800) 345-2460 or visit us at www.anthem.com

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