Your Anthem Benefits

Anthem

State of Indiana – Traditional Plan

Summary of Benefits, Effective January 1, 2023

Please note: As we receive additional guidance and clarification on federal health care reform from the U.S. Department of Health and Human Services, we may be required to make additional changes to your benefits.

Covered Benefits	Tier 1 HealthSync	Tier 2 In-Network	Out-of-Network
Deductible *Family coverage requires the family deductible to be met before coinsurance applies. The single deductible **does not** apply to family coverage.* *(Deductible cross-applies for all Tiers)*	Single: $750 Family: $1,500	Single $1,000 Family $2,000	Single $1,000 Family $2,000
Out-of-Pocket Limit (OOP) (Single/Family) *Family coverage requires the family OOP to be met before 100% coverage applies. The single OOP **does not** apply to family coverage.* *(Out-of-Pocket cross-applies for all Tiers)*	Single: $2,000 Family: $4,000	Single $2,500 Family $5,000	Single $2,500 Family $5,000
Physician Home and Office Services Primary Care Physician (PCP)/Specialty Care Physician (SCP) Including office surgeries and allergy serum: • allergy injections (PCP and SCP) and allergy testing • non-routine mammograms • diabetic education (regardless of outpatient setting) • MRAs, MRIs, PETS, C-scans, nuclear cardiology imaging studies and non-maternity related ultrasounds	10%	30%	50%
Preventive Care Services Services include but are not limited to: Annual physical exams, pelvic exams, pap testing, PSA tests, immunizations, routine vision, and hearing screenings. Vision screening limited to basic screening in PCP office. • Physician home and office visits (PCP/SCP) • Other outpatient services at hospital/alternative care facility • Routine mammograms • Screening colorectal cancer exam/laboratory testing **All preventive services are limited to one of each service per year per covered member; if the office visit is billed separately or if the primary purpose of the office visit is not for the delivery of a preventive service, cost sharing may be imposed for the office visit**	No deductible /coinsurance	No deductible /coinsurance	50% (not subject to deductible)
Emergency and Urgent Care • **Emergency Room services at hospital (facility/other covered services)** • **Urgent Care Center services**	 10% 10%	 10% 30%	 10% 50%
Maternity Services	10%	30%	50%
Inpatient and Outpatient Professional Services Include but are not limited to: • Medical care visits, intensive medical care, concurrent care, consultations, surgery and administration of general anesthesia and Newborn exams	10%	30%	50%
Inpatient Facility Services	10%	30%	50%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	10%	30%	50%
Other Outpatient Services *(including but not limited to):* • Non-surgical outpatient services for example: MRIs, C-scans, chemotherapy, ultrasounds, and other diagnostic outpatient services. • Home care services (Tier 1 & 2 in-network/out-of-network combined) (includes IV therapy) **(No RN/LPN unless billed through a home health care agency)** • Durable medical equipment and orthotics (Tier 1 & 2 in-network/out-of-network combined) (including medical supplies) • Prosthetic devices for prosthetics received on an outpatient basis. (Surgical prosthetics do not apply) • Physical medicine therapy day rehabilitation programs	10%	30%	50%

Covered Benefits	Tier 1 HealthSync	Tier 2 In-Network	Out-of-Network
• Hospice care • Ambulance services	10%	30%	50%
Outpatient Therapy Services (Limits apply) • Physician Home and Office Visits (PCP/SCP) • Other outpatient services at hospital/alternative care facility • Physical therapy: 25 visits • Occupational therapy: 25 visits • Manipulation therapy: 12 visits • Speech therapy: 25 visits	10%	30%	50%
Behavioral Health Services: **Mental Health and Substance Abuse**[1] • Inpatient facility services • Physician home and office visits (PCP/SCP) • Other outpatient services at hospital/alternative care facility **Certain MH/SA services may require precertification; refer to the plan certificate for details.**	10%	30%	50%
Human Organ and Tissue Transplants[2] • Acquisition and transplant procedures, harvest, and storage	10%	30%	50%

Prescription Drug Coverage – THIS COVERAGE IS ADMINISTERED BY CVS CAREMARK

	Prescription Drug Coverage Deductible must be met before coinsurance rates apply		
	Retail Pharmacy Network (Up to 30-day supply)	Mail Order Pharmacy (Up to 90-day supply)	Retail Pharmacy Network (Up to 90-day supply)
Preventive Medicines (mandated by the ACA)	$0 (no deductible)	$0 (no deductible)	$0 (no deductible)
Generic Medicines	$10 copay	$20 copay	$30 copay
Preferred Brand-Name Medicines	20% Min $30. Max $50	20% Min $60, Max $100	20% Min $90, Max $150
Non-Preferred Brand-Name Medicines	40% Min $50, Max $70	40% Min $100, Max $140	40% Min $150, Max $210
Specialty Medicines	40% Min $75, Max $150 (30-day supply)		

Notes:

- *Non-network human organ and tissue transplants are excluded from the out-of-pocket limits.*
- *Dependent Age: to end of the month in which the child attains age 26*
- *No copayment/coinsurance 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.*
- *Benefit Period = calendar year.*
- *Private Duty Nursing – limited to 82 visits/Calendar Year and 164 visits/lifetime.*
- *Skilled Nursing Facility – limited to 100 days.*

[1]*We encourage you to contact our mental health subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits for limitations.*
[2]*Cornea is treated the same as any other illness and subject to the medical benefits*
[3]*PRESCRIPTION BENEFITS ADMINISTERED BY CVS/CAREMARK. ANY QUESTIONS RELATED TO RX NEED TO BE DIRECTED TO* ***(866)234-6869***

Precertification:

- *Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.*

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.