Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Plan: Indiana State University: HDHP

Your Network: BlueCard PPO

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	20% coinsurance after deductible is met
Mental Health & Substance Use Disorder Services	20% coinsurance after deductible is met
Specialist care	20% 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
Overall Deductible	$2,000 person / $4,000 family	$6,000 person / $18,000 family
Overall Out-of-Pocket Limit	$5,000 person / $10,000 family	$19,650 person / $39,300 family
The family deductible is non-embedded, meaning when more than a single person is enrolled, the per person deductible does not apply and the family deductible must be met by any one person or collection of persons. The out-of-pocket limit is embedded, meaning each covered person is capped at his or her per person out-of-pocket limit. All medical deductibles, copayments and coinsurance apply to the out-of-pocket limit. The In-Network and Out-of-Network deductibles and out-of-pocket limits 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 *virtual and office*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Specialist Care *virtual and office*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Practitioner Visits		
Maternity Doctor services (prenatal/postnatal care and delivery)	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 60 visits per benefit period.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Other Services in an Office		
Allergy Testing	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Surgery	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	50% coinsurance after deductible is met
Diagnostic Services		
Lab		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Lab/Reference Lab	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
X-Ray		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Emergency Room Facility Services	20% coinsurance after deductible is met	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	Covered as In-Network
Ambulance	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Ambulatory Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Physician and other services *including surgeon fees*		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Ambulatory Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)		
Facility Fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Human Organ and Tissue Transplants *Cornea transplants are treated the same as any other illness and subject to the medical benefits.*	20% coinsurance after deductible is met	Not covered
Physician and other services *including surgeon fees*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Home Health Care *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for physical, occupational, speech and pulmonary therapies is limited to 60 visits combined per benefit period.*		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Pulmonary rehabilitation *office and outpatient hospital* *Coverage is limited to 60 visits per benefit period combined with physical, occupational and speech therapies.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation *office and outpatient hospital* *Coverage is limited to 36 days per benefit period.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Chemo/Radiation Therapy *office and outpatient hospital*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (facility)	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Inpatient Hospice *Coverage is limited to life expectancy up to 12 months.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 unit after cancer treatment per benefit period.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible	Combined with Medical	Not covered
Pharmacy Out-of-Pocket Limit	Combined with Medical	Not covered
Prescription Drug Coverage **Network: Caremark** **Drug List: National Formulary**		
Day Supply Limits: 90 day supply if allowed by law		

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Tier 1 - Typically Generic	20% coinsurance	Not covered (retail and home delivery)
Tier 2 - Typically Preferred Brand	20% coinsurance	Not covered (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand	20% coinsurance	Not covered (retail and home delivery)
Tier 4 - Typically Specialty (brand and generic)	20% coinsurance	Not covered (retail and home delivery)

Notes:

- Dependent Age Limit: to the end of the year 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.

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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Questions: (844) 416-6383 or visit us at www.anthem.com

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(TTY/TDD: 711)

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