Your summary of benefits

Anthem® Blue Cross and Blue Shield

The Heritage Employee Benefit Trust – Effective: 01-01-2025

Your Plan: Anthem Blue Access PPO HSA PrevRx High Plan

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	No charge after deductible is met
Mental Health & Substance Use Disorder Services	No charge after deductible is met
Specialist care	10% 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 **Non-embedded**	$4,000 person / $8,000 family	$8,000 person / $16,000 family
Overall Out-of-Pocket Limit *embedded*	$5,000 person / $10,000 family	$10,000 person / $20,000 family
The family deductible is non-embedded, which requires the family deductible to be met before coinsurance applies. The family out-of-pocket limit is embedded, meaning the cost shares of one family member will be applied to the per person out-of-pocket limit; in addition, amounts for all covered family members apply to the family out-of-pocket limit. No one member will pay more than the 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 *virtual and office*	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Specialist Care *virtual and office*	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Other Practitioner Visits		
Maternity Doctor services (prenatal/postnatal care and delivery)	10% 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
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 10 visits per benefit period.*	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Other Services in an Office		
Allergy Testing	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Surgery	10% coinsurance 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 *per IRS guidelines*	No charge	30% coinsurance after deductible is met
Diagnostic Services		
Lab		
Office	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Lab/Reference Lab	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	30% coinsurance after deductible is met
X-Ray		
Office	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Radiology Center	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	10% 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
Emergency and Urgent Care		
Urgent Care	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Emergency Room Facility Services	10% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	10% coinsurance after deductible is met	Covered as In-Network
Ambulance *Authorized Out-of-Network non-emergency ambulance services are limited to an Anthem maximum payment of $50,000 per trip.*	10% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor Services	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Ambulatory Surgical Center	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Physician and other services *including surgeon fees*		
Hospital	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Ambulatory Surgical Center	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)		
Facility Fees	10% coinsurance after deductible is met	30% 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.*	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Physician and other services *including surgeon fees*	10% 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 *Coverage is limited to 100 visits per benefit period.*	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for physical and occupational therapies is limited to 40 visits combined per benefit period. Coverage for speech therapy is unlimited visits per benefit period.*		
Office	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Pulmonary rehabilitation *office and outpatient hospital* *Coverage is limited to 20 visits per benefit period.*	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Cardiac rehabilitation *office and outpatient hospital* *Coverage is limited to 36 visits per benefit period.*	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy *office and outpatient hospital*	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage for Skilled Nursing is limited to 90 days per benefit period.*	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Inpatient Hospice	10% coinsurance after deductible is met	Covered as In-Network
Durable Medical Equipment	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	10% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with Out-of-Network medical deductible
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Out-of-Network medical out-of-pocket limit

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Prescription Drug Coverage **Network:** ***Base Network*** **Drug List:** ***National*** *Drugs not included on the drug list will not be covered.*		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies noted below applies).* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.* **Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy. Drug cost share assistance programs may be available for certain specialty drugs.*		
Preventive Drugs *No deductible, copayment or coinsurance applies to prescription drugs on the PreventiveRX Enhanced drug list when you use a Preferred Network or an In-Network Pharmacy.*		
Tier 1 - Typically Generic	10% coinsurance after deductible is met (retail and home delivery)	Greater of $75 or 50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 - Typically Preferred Brand	10% coinsurance after deductible is met (retail and home delivery)	Greater of $75 or 50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	10% coinsurance after deductible is met (retail and home delivery)	Greater of $75 or 50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	10% coinsurance after deductible is met (retail and home delivery)	Greater of $75 or 50% coinsurance after deductible is met (retail) and Not covered (home delivery)

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.

Questions: (833) 578-4441 or visit us at www.anthem.com