

# State of Indiana: CDHP1

## 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: CDHP



**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://coc.anthem.com/eocdps/aso> or by calling (877) 814-9709.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	<p><b>\$2,500</b> individual / <b>\$5,000</b> family for In-Network Providers. Does not apply to Preventive care.</p> <p><b>\$2,500</b> individual / <b>\$5,000</b> family for Out-of-Network Providers. Does not apply to Preventive care.</p> <p>In-Network Providers and Non-Network Providers deductibles are combined. Satisfying one helps satisfy the other.</p>	<p>You must pay all costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u>.</p>
Are there other <u>deductibles</u> for specific services?	No.	<p>You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 3 for other costs for services this plan covers.</p>
Is there an <u>out-of-pocket limit</u> on my expenses?	<p>Yes; <b>\$4,000</b> individual / <b>\$7,150</b> individual on a family contract</p> <p><b>\$8,000</b> family for In-Network Providers.</p> <p><b>\$4,000</b> individual / <b>\$8,000</b> family for Out-of-Network Providers.</p> <p>In-Network Providers and Non-Network Providers Out of</p>	<p>The <u>out-of-pocket limit</u> 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.</p>

**Questions:** Call (877) 814-9709 or visit us at [www.anthem.com](http://www.anthem.com)

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call (877) 814-9709 to request a copy.

Important Questions	Answers	Why this Matters:
	Pocket are combined. Satisfying one helps satisfy the other.	
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Services deemed not medically necessary by medical management and/or anthem, Penalties for non-compliance, 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 <b><u>out-of-pocket limit</u></b> .
<b>Is there an overall annual limit on what the plan pays?</b>	No.	The chart starting on page 3 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
<b>Does this plan use a <u>network of providers</u>?</b>	Yes, National Blue Card PPO. For a list of In-Network providers, see <a href="http://www.anthem.com">www.anthem.com</a> or call (877) 814-9709.	If you use an in-network doctor or other health care <b><u>provider</u></b> , 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 <b><u>provider</u></b> for some services. Plans use the term in-network, <b><u>preferred</u></b> , or participating for <b><u>providers</u></b> in their <b><u>network</u></b> . See the chart starting on page 3 for how this plan pays different kinds of <b><u>providers</u></b> .
<b>Do I need a referral to see a <u>specialist</u>?</b>	No; you do not need a referral to see a specialist.	You can see the <b><u>specialist</u></b> you choose without permission from this plan.
<b>Are there services this plan doesn't cover?</b>	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about <b><u>excluded services</u></b> .



- **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 **In-Network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider’s office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	-----none-----
	Specialist visit	20% coinsurance	40% coinsurance	-----none-----
	Other practitioner office visit	Manipulative Therapy 20% coinsurance Acupuncture Not covered	Manipulative Therapy 40% coinsurance Acupuncture Not covered	Manipulative Therapy Coverage for In-Network Providers and Out-of-Network Providers combined is limited to 12 visits per benefit period. Acupuncture -----none-----
	Preventive care/screening/immunization	No cost share	40% coinsurance	-----none-----
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office 20% coinsurance X-Ray – Office 20% coinsurance	Lab – Office 40% coinsurance X-Ray – Office 40% coinsurance	Lab – Office Pre-certification may be required. X-Ray – Office Pre-certification may be required.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Pre-certification may be required.
If you need drugs to treat your illness or condition	Tier 1 - Typically Generic	\$10 copay per prescription (retail only) \$20 copay per prescription (home delivery only)	Not covered	Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery)

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
More information about <b>prescription drug coverage</b> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a> or call 1-877-941-5241.				Benefit applies deductible and accumulates to Out-of-Pocket Maximum
	Tier 2 - Typically Preferred / Brand	20% coinsurance min \$30, up to \$50 per prescription (retail only) 20% coinsurance min \$60, up to \$100 per prescription (home delivery only)	Not covered	Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery) Benefit applies deductible and accumulates to Out-of-Pocket Maximum
	Tier 3 - Typically Non-Preferred / Specialty Drugs	40% coinsurance min \$50, up to \$70 per prescription (retail only) 40% coinsurance min \$100, up to \$140 per prescription (home delivery only)	Not covered	Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery) Benefit applies deductible and accumulates to Out-of-Pocket Maximum
	Tier 4 - Typically Specialty Drugs	40% coinsurance min \$75, up to \$150 per prescription (retail and home delivery)	Not covered	Covers up to a 30 day supply (retail pharmacy) Covers up to a 30 day supply (home delivery) Benefit applies deductible and accumulates to Out-of-Pocket Maximum
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	-----none-----
	Physician/surgeon fees	20% coinsurance	40% coinsurance	-----none-----
<b>If you need immediate medical attention</b>	Emergency room services	20% coinsurance	Covered as In-Network	Pre-certification may be required.
	Emergency medical transportation	20% coinsurance	Covered as In-Network	-----none-----
	Urgent care	20% coinsurance	Covered as In-Network	-----none-----
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	-----none-----
	Physician/surgeon fee	20% coinsurance	40% coinsurance	-----none-----
<b>If you have mental health,</b>	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit	Mental/Behavioral Health Office Visit	Mental/Behavioral Health Office Visit

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
<b>behavioral health, or substance abuse needs</b>		20% coinsurance Mental/Behavioral Health Facility Visit - Facility Charges 20% coinsurance	40% coinsurance Mental/Behavioral Health Facility Visit - Facility Charges 40% coinsurance	-----none----- Mental/Behavioral Health Facility Visit - Facility Charges -----none-----
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	-----none-----
	Substance use disorder outpatient services	Substance Use Office Visit 20% coinsurance Substance Use Facility Visit - Facility Charges 20% coinsurance	Substance Use Office Visit 40% coinsurance Substance Use Facility Visit - Facility Charges 40% coinsurance	Substance Use Office Visit -----none----- Substance Use Facility Visit - Facility Charges -----none-----
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	-----none-----
<b>If you are pregnant</b>	Prenatal and postnatal care	20% coinsurance	40% coinsurance	-----none-----
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	Pre-certification may be required.
<b>If you need help recovering or have other special health needs</b>	Home health care	20% coinsurance	40% coinsurance	-----none-----
	Rehabilitation services	20% coinsurance	40% coinsurance	Coverage is limited to 25 visits per benefit period for Physical Therapy. Coverage is limited to 25 visits per benefit period for Occupational Therapy. Coverage is limited to 25 visits per benefit period for Speech Therapy. Apply to In-Network Providers and Out-of-Network Providers combined.
	Habilitation services	20% coinsurance	40% coinsurance	Habilitation visits count towards your rehabilitation limit.
	Skilled nursing care	20% coinsurance	40% coinsurance	Coverage for In-Network Providers and Out-of-Network Providers combined is limited to 100 days limit per benefit period.

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
	Durable medical equipment	20% coinsurance	40% coinsurance	Pre-certification may be required.
	Hospice service	20% coinsurance	20% coinsurance	-----none-----
<b>If your child needs dental or eye care</b>	Eye exam	20% coinsurance	40% coinsurance	-----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 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](http://www.bcbs.com/bluecardworldwide)
- Private-duty nursing only covered in the home. Coverage is limited to 82 visits per benefit period. Coverage is limited to 164 visits per lifetime.
- Routine eye care (adult) Covered only at Primary care provider.

## 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 (877) 814-9709. 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](http://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](http://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: Grievance and Appeals  
P.O. Box 105568  
Atlanta, GA 30348-5568

State of Indiana Department of Insurance  
311 W. Washington Street, Suite 300  
Indianapolis, Indiana 46204  
(800) 622-4461 or (317) 232-2395

Prescription Drugs:  
Express Scripts  
1-877-841-5241

## 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 does 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 does 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 adoolwol íínízinigo t'áá diné k'éjígoo, t'áá shoodí ba na'alníhí ya sidáhí bich'í naabídíílkíid. Eí doo biigha daago ni ba'nija'go ho'aalagí bich'í hodiilní. Hai'daa iini'taago eíya, t'áá shoodí diné ya atáh halne'ígú ní béesh bee hane'í wólta' bi'ki si'niilígú bi'kéhgo bich'í 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.

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

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## 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 \$3,920
- Patient pays \$3,620

#### 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
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$2,500
Copays	\$0
Coinsurance	\$950
Limits or exclusions	\$170
<b>Total</b>	<b>\$3,620</b>

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

- Amount owed to providers: \$5,400
- Plan pays \$50
- Patient pays \$5,350

#### 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
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$2,420
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$2,930
<b>Total</b>	<b>\$5,350</b>

# 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.

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## Language Access Services:

(TTY/TDD: 711)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (877) 814-9709.

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (877) 814-9709 သို့ ခေါ်ဆိုပါ။

Chinese (中文): 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (877) 814-9709。

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (877) 814-9709.

French (Français): Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (877) 814-9709.

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (877) 814-9709.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (877) 814-9709 ।

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(877) 814-9709 にお電話ください。

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (877) 814-9709 로 문의하십시오.

Pennsylvania Dutch (Deutsch): Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Hilfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff (877) 814-9709 aa.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (877) 814-9709 ਤੇ ਕਾਲ ਕਰੋ।

## Language Access Services:

**Russian (Русский):** если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (877) 814-9709.

**Spanish (Español):** Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (877) 814-9709.

**Tagalog (Tagalog):** Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (877) 814-9709.

**Vietnamese (Tiếng Việt):** Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (877) 814-9709.