Your summary of benefits

Anthem® Blue Cross and Blue Shield

DNR/Excise – Active

Your Plan: Anthem Blue Access PPO

Your Network: Blue Access

Effective 01/01/2026

Visits with Virtual Care Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	$0 copay per visit medical deductible does not apply
Mental Health & Substance Use Disorder Services	$0 copay per visit medical deductible does not apply
Specialist care	20% coinsurance after medical 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 *Your plan applies a separate Pharmacy Deductible to prescription drugs obtained at a pharmacy. See the Covered Prescription Drug Benefits section.*	$1,000 person / $2,000 family	$1,000 person / $2,000 family
Overall Out-of-Pocket Limit	$3,500 person / $7,000 family	$3,500 person / $7,000 family
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or 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 Non-Network deductibles and out-of-pocket limit amounts are combined and 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 medical deductible is met	40% coinsurance after medical deductible is met
Specialist Provider *virtual and office*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Other Practitioner Visits		
Maternity Doctor services (prenatal/postpartum care and delivery)	20% coinsurance after medical deductible is met	40% coinsurance after medical 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 medical deductible is met	40% coinsurance after medical deductible is met

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 medical deductible is met	40% coinsurance after medical deductible is met
Prescription Drugs *Dispensed in the office*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Surgery	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Preventive care / screenings / immunizations	No charge	40% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	40% coinsurance after medical deductible is met
Diagnostic Services Lab		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Freestanding Lab/Reference Lab	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Diagnostic Services X-Ray		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Diagnostic Services Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Freestanding Radiology Center	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical 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	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Emergency Room Facility Services	20% coinsurance after medical deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after medical deductible is met	Covered as In-Network
Ambulance	20% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Doctor Services	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Ambulatory Surgical Center	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Physician and other services *including surgeon fees*		
Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Ambulatory Surgical Center	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)		
Facility Fees	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In Network Provider	Cost if you use an Out of Network Provider
Human Organ and Tissue Transplants *Cornea transplants are treated as medical procedures, with benefits and cost sharing determined by the setting in which the services are received.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Physician and other services *including surgeon fees*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Home Health Care *Coverage is limited to 100 visits per benefit period.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Therapy Services		
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for occupational therapy is unlimited visits per benefit period, physical therapy is limited to 90 visits per benefit period and speech therapy is unlimited visits per benefit period.*		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Manipulation Therapy *office and outpatient hospital* *Coverage is limited to 90 visits per benefit period.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Pulmonary rehabilitation *office and outpatient hospital* *Coverage is limited to 20 visits per benefit period.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Cardiac rehabilitation *office and outpatient hospital* *Coverage is limited to 36 visits per benefit period.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Chemo/Radiation Therapy *office and outpatient hospital*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Coverage for Skilled Nursing is limited to 90 days per benefit period.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Inpatient Hospice	20% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Additional Services, Equipment and Devices		

Covered Medical Benefits	Cost if you use an In Network Provider	Cost if you use an Out of Network Provider
Durable Medical Equipment	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prosthetic Devices	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Wigs *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

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

Your summary of benefits

Anthem

Your Plan: Anthem Blue Access PPO Option 23 with Rx Option T5

Your Network: Blue Access

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.