State of Indiana: Consumer Driven Health Plan 2 (CDHP 2)

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, https://eoc.anthem.com/eocdps/aso. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call (877) 814-9709 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$3,000/person or $6,000/family for Tier 1 HealthSync Preferred Network Providers. $6,000/person or $12,000/family for Tier 2 In-Network Providers. $7,500/person or $15,000/family for Out-of-Network Providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay. All provider tiers cross-accumulate toward the deductible; the provider tier determines claim payment.
Are there services covered before you meet your deductible?	Yes. Preventive Care. For more information see below.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$5,000/person or $10,000/family for Tier 1 HealthSync Preferred Network Providers. $8,000/person or $16,000/family for Tier 2 In-Network Providers. $9,500/person or $19,000/family for Out-of-Network Providers. $12,000 individual embedded out-of-pocket maximum for Tier 2 family coverage.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met. All provider tiers cross-accumulate toward the out-of-pocket maximum. Deductibles, copayments, and coinsurance count toward this limit.

What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover and Out-of-Network Transplants.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com/find-care/?alphaprefix=K6Z or call (877) 814-9709 for a list of network providers. Benefits and costs may vary by site of service and how the provider bills.	You pay the least if you use a provider in Tier 1 HealthSync Preferred Network. You pay more if you use a provider in Tier 2 In-Network. You will pay the most if you use a Tier 3 Out-of-Network Provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an Out-of-Network for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 HealthSync Preferred Network Provider (You will pay the least)	Tier 2 In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	60% coinsurance	--------none--------
	Specialist visit	20% coinsurance	40% coinsurance	60% coinsurance	--------none--------
	Preventive care/screening/ immunization	No charge	No charge	60% coinsurance, deductible does not apply	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	60% coinsurance	--------none--------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	60% coinsurance	--------none--------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is	Typically Generic	$10/prescription (30 day retail) $30/prescription (90 day retail) and $20/prescription (90 day home delivery)	Same as Preferred Network	Reimbursed based on coinsurance for Preferred Network and member also pays any difference between the	*See Prescription Drug section. Prescription drug deductible, copays, and coinsurance apply to Tier 1 HealthSync Preferred Network Providers. Pharmacy Benefit Management Services are

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 HealthSync Preferred Network Provider (You will pay the least)	Tier 2 In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
available at www.caremark.com				pharmacy charge and the allowable costs.	provided by CVS Caremark. Up to a 90 day supply is available at CVS Caremark Mail Order Pharmacy or at participating Retail Pharmacy Locations. ACA-mandated preventive medicines: no charge, deductible waived. Prescription drug cost sharing applies to Tier 1 and counts toward the out-of-pocket maximum.
	Typically Preferred Brand & Non-Preferred Generic Drugs	Greater of $30 or 20% coinsurance up to $50/prescription (30 day retail) Greater of $90 or 20% coinsurance up to $150/prescription (90 day retail) and Greater of $60 or 20% coinsurance up to $100/prescription (90 day home delivery)	Same as Preferred Network	Reimbursed based on coinsurance for Preferred Network and member also pays any difference between the pharmacy charge and the allowable costs.	
	Typically Non-Preferred Brand and Generic drugs	Greater of $50 or 40% coinsurance up to $70/prescription (30 day retail) Greater of $150 or 40% coinsurance up to $210/prescription (90 day retail) and Greater of $100 or 40% coinsurance up to $140/prescription (90 day home delivery)	Same as Preferred Network	Reimbursed based on coinsurance for Preferred Network and member also pays any difference between the pharmacy charge and the allowable costs.	

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 HealthSync Preferred Network Provider (You will pay the least)	Tier 2 In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Typically Preferred Specialty (brand and generic)	Greater of $75 or 40% coinsurance up to $150/prescription (30 day retail and home delivery)	Same as Preferred Network	Reimbursed based on coinsurance for Preferred Network and member also pays any difference between the pharmacy charge and the allowable costs.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	60% coinsurance	--------none--------
	Physician/surgeon fees	20% coinsurance	40% coinsurance	60% coinsurance	--------none--------
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	20% coinsurance (emergency care; in-network cost sharing)	--------none--------
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance (emergency transportation; in-network cost sharing)	Non-emergency Out-of-Network Ambulance Services are limited to $50,000 per trip, does not apply to air ambulance.
	Urgent care	20% coinsurance	40% coinsurance	60% coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	60% coinsurance	--------none--------
	Physician/surgeon fees	20% coinsurance	40% coinsurance	60% coinsurance	--------none--------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit 20% coinsurance Other Outpatient 20% coinsurance	Office Visit 40% coinsurance Other Outpatient 40% coinsurance	Office Visit 60% coinsurance Other Outpatient 60% coinsurance	Office Visit --------none-------- Other Outpatient --------none--------
	Inpatient services	20% coinsurance	40% coinsurance	60% coinsurance	--------none--------
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	60% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	60% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	60% coinsurance	

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 HealthSync Preferred Network Provider (You will pay the least)	Tier 2 In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	60% coinsurance	--------none--------
	Rehabilitation services	20% coinsurance	40% coinsurance	60% coinsurance	*See Therapy Services section.
	Habilitation services	20% coinsurance	40% coinsurance	60% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	60% coinsurance	100 days/benefit period for skilled nursing services.
	Durable medical equipment	20% coinsurance	40% coinsurance	60% coinsurance	*See Durable Medical Equipment section.
	Hospice services	20% coinsurance	40% coinsurance	60% coinsurance	--------none--------
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	--------none--------
	Children's glasses	Not covered	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Not covered	--------none--------

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Dental care (Adult)
- Hearing aids
- Routine eye care (Adult)
- Children's dental check-up
- Eye exams for a child
- Infertility treatment
- Routine foot care unless medically necessary
- Cosmetic surgery
- Glasses for a child
- Long-term care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Private-duty nursing 82 visits/benefit period and 164 visits/lifetime in a Home Setting only
- Chiropractic care 12 visits/benefit period
- Most coverage provided outside the United States. See www.bcbsglobalcore.com

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State of Indiana Department of Insurance, 311 W. Washington Street, Suite 300, Indianapolis, Indiana 46204, (800) 622-4461, (317) 232-2395, www.in.gov/idoi/3008.htm, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov, or contact Anthem at the number on the back of your ID card. Other coverage options may be available to you, too, including

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buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

ATTN: Grievances and Appeals, P.O. Box 105568, Atlanta GA 30348-5568

Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

The plan's overall deductible	**$3,000**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$10
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,970**

The plan's overall deductible	**$3,000**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$70
Coinsurance	$500
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,590**

The plan's overall deductible	**$3,000**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

The plan would be responsible for the other costs of these EXAMPLE covered services.

We’re here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here’s the English version: “You have the right to get help in your language for free. Just call the Member Services number on your ID card.” Visually impaired? You can also ask for other formats of this document.

TTY/TTD:711

It’s important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don’t discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn’t English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf