


Summary of Benefits and Coverage: What this **Plan** Covers & What You Pay For Covered Services Coverage Period: 10/01/2017– 09/30/2018  
 Wabash Valley/West Central Indiana School Trust: Blue Access for Health Savings Coverage for: Individual + Family | Plan Type: CDHP  
 Accounts



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/](http://www.healthcare.gov/sbc-glossary/) or call (800) 345-2460 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <b>deductible</b> ?	\$3,350/single or \$6,650/family for In- <b>Network Providers</b> . \$6,700/single or \$13,300/family for Out-of- <b>Network Providers</b> .	Generally, you must pay all of the costs from <b>providers</b> up to the <b>deductible</b> amount before this <b>plan</b> begins to pay. If you have other family members on the <b>plan</b> , each family member must meet their own individual <b>deductible</b> until the total amount of <b>deductible</b> expenses paid by all family members meets the overall family <b>deductible</b> .
Are there services covered before you meet your <b>deductible</b> ?	Yes. <b>Preventive care</b> for In- <b>Network Providers</b> .	This <b>plan</b> covers some items and services even if you haven't yet met the <b>deductible</b> amount. But a <b>copayment</b> or <b>coinsurance</b> may apply. For example, this <b>plan</b> covers certain preventive services without <b>cost-sharing</b> and before you meet your <b>deductible</b> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet <b>deductibles</b> for specific services.
What is the <b>out-of-pocket limit</b> for this <b>plan</b> ?	\$3,350/single or \$6,650/family for In- <b>Network Providers</b> . \$6,700/single or \$13,300/family for Out-of- <b>Network Providers</b> .	The <b>out-of-pocket limit</b> is the most you could pay in a year for covered services. If you have other family members in this <b>plan</b> , they have to meet their own <b>out-of-pocket limits</b> until the overall family <b>out-of-pocket limit</b> has been met.
What is not included in the <b>out-of-pocket limit</b> ?	Non- <b>Network</b> Transplant Services, <b>Premiums</b> , <b>balance-billing</b> charges, and health care this <b>plan</b> doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
Will you pay less if you use a <b>network provider</b> ?	Yes, Blue Access. See <a href="http://www.anthem.com">www.anthem.com</a> or call (800) 345-2460 for a list of <b>network providers</b> .	This <b>plan</b> uses a <b>provider network</b> . You will pay less if you use a <b>provider</b> in the <b>plan's network</b> . You will pay the most if you use an out-of- <b>network provider</b> , and you might receive a bill from a <b>provider</b> for the difference between the <b>provider's</b> charge and what your <b>plan</b> pays ( <b>balance billing</b> ). Be aware your <b>network provider</b> might use an out-of- <b>network provider</b> .

		for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a referral to see a specialist?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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
		Network Provider (You will pay the least)	Non-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	0% <u>coinsurance</u>	30% <u>coinsurance</u>	-----none-----
	Specialist visit	0% <u>coinsurance</u>	30% <u>coinsurance</u>	-----none-----
	Preventive care/ <u>screening</u> / immunization	No charge	30% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	0% <u>coinsurance</u>	30% <u>coinsurance</u>	-----none-----
	Imaging (CT/PET scans, MRIs)	0% <u>coinsurance</u>	30% <u>coinsurance</u>	-----none-----
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a> National	Tier 1 - Typically Generic	0% <u>coinsurance</u> (retail) and 0% <u>coinsurance</u> (home delivery)	30% <u>coinsurance</u> (retail)	*See <u>Prescription Drug</u> section
	Tier 2 - Typically Preferred / Brand	0% <u>coinsurance</u> (retail) and 0% <u>coinsurance</u> (home delivery)	30% <u>coinsurance</u> (retail)	
	Tier 3 - Typically Non-Preferred / Specialty Drugs	0% <u>coinsurance</u> (retail) and 0% <u>coinsurance</u> (home delivery)	30% <u>coinsurance</u> (retail)	
	Tier 4 - Typically Specialty (brand and generic)	0% <u>coinsurance</u> (retail) and 0% <u>coinsurance</u> (home delivery)	30% <u>coinsurance</u> (retail)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% <u>coinsurance</u>	30% <u>coinsurance</u>	-----none-----
	Physician/surgeon fees	0% <u>coinsurance</u>	30% <u>coinsurance</u>	-----none-----
If you need immediate medical attention	<u>Emergency room care</u>	0% <u>coinsurance</u>	Covered as In-Network	-----none-----
	<u>Emergency medical transportation</u>	0% <u>coinsurance</u>	Covered as In-Network	-----none-----
	<u>Urgent care</u>	0% <u>coinsurance</u>	30% <u>coinsurance</u>	-----none-----

\* For more information about limitations and exceptions, see plan or policy document at <https://eoc.anthem.com/eocdps/aso>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	30% coinsurance	-----none-----
	Physician/surgeon fees	0% coinsurance	30% coinsurance	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit 0% coinsurance	Office Visit 30% coinsurance	Office Visit -----none-----
		Other Outpatient 0% coinsurance	Other Outpatient 30% coinsurance	Other Outpatient -----none-----
		Inpatient services 0% coinsurance	30% coinsurance	-----none-----
If you are pregnant	Office visits	0% coinsurance	30% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	0% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	30% coinsurance	100 visits/benefit period.
	Rehabilitation services	0% coinsurance	30% coinsurance	*See Therapy Services section
	Habilitation services	0% coinsurance	30% coinsurance	
	Skilled nursing care	0% coinsurance	30% coinsurance	-----none-----
	Durable medical equipment	0% coinsurance	30% coinsurance	-----none-----
	Hospice services	10% coinsurance	10% coinsurance	-----none-----
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	*See Vision Services section
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	*See Dental Services section

**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          | • Bariatric surgery        | • Cosmetic surgery  |
| • Dental care (adult)  | • Hearing aids             | • Infertility treatment   |
| • Long-term care       | • Routine eye care (adult) | • Routine foot care unless you have been diagnosed with diabetes. |
| • Weight loss programs |                            |   |

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

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|---|--|------------------------|
| • Chiropractic care 50 visits/benefit period. | • Most coverage provided outside the United States. See <a href="http://www.bcbsglobalcore.com">www.bcbsglobalcore.com</a> | • Private-duty nursing |
|---|--|------------------------|

\* For more information about limitations and exceptions, see **plan** or policy document at <https://eoc.anthem.com/eocdps/aso>.

**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: Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://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 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 Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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.*-----

\* For more information about limitations and exceptions, see plan or policy document at <https://eoc.anthem.com/eocdps/aso>.

**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.

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$3,350
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

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	\$12,840
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$3,350
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,410

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$3,350
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

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	\$7,460
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$3,350
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$3,405

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The plan's overall deductible \$3,350
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

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	\$2,010
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,925
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,925

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