Your summary of benefits

Anthem®

Anthem® Blue Cross and Blue Shield

Mase Insurance Trust

Effective 01/01/2027

Your Plan: Anthem Blue Access PPO

Plan 1

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	$40 copay per visit medical deductible does not apply
Mental Health & Substance Use Disorder Services	$40 copay per visit medical deductible does not apply
Specialist care	$60 copay per visit medical deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	$1,500 person / $3,000 family	$3,000 person / $6,000 family
Overall Out-of-Pocket Limit	$3,500 person / $6,000 family	$7,000 person / $12,000 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 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) *virtual and office*	$40 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Mental Health and Substance Use Disorder Services *virtual and office*	$40 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Specialist Provider *virtual and office*	$60 copay per visit medical deductible does not apply	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

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.*	$40 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Other Services in an Office		
Allergy Testing	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Allergy Injections	$5 copay per visit medical deductible does not apply	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	$60 copay per visit medical deductible does not apply‡	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	Cost share is based on the setting services are received.
Diagnostic Services Lab		
Office	No charge	40% coinsurance after medical deductible is met
Freestanding Lab/Reference Lab	No charge	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	No charge	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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
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
Emergency and Urgent Care		
Urgent Care	$75 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Emergency Room Facility Services *Your copay will be waived if admitted.*	$300 copay per visit medical deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
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
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. You must get certain covered transplant procedures from an Approved In-Network Provider to receive the In-Network level of benefits.*	No charge	50% 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 unlimited 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 physical, occupational and speech therapies are unlimited visits combined per benefit period.*		
Office	$60 copay per visit medical deductible does not apply	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 *Coverage is unlimited visits per benefit period.*		
Office	$60 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Pulmonary rehabilitation *Coverage is unlimited visits per benefit period.*		
Office	$60 copay per visit medical deductible does not apply	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
Cardiac rehabilitation *Coverage is unlimited visits per benefit period.*		
Office	$60 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Dialysis/Hemodialysis		
Office	No charge	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Chemo/Radiation Therapy		
Office	$60 copay per visit medical deductible does not apply‡	40% coinsurance after medical deductible is met
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 unlimited days per benefit period.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Inpatient Hospice	No charge	Covered as In-Network
Additional Services, Equipment and Devices		
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	20% coinsurance after medical deductible is met	40% coinsurance after medical 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	Not applicable	Not covered
Pharmacy Out-of-Pocket Limit	$4,500 person / $9,000 family	Not covered
Prescription Drug Coverage **Network:** ***Base Network*** **Drug List:** ***National Direct Preferred*** *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.*		
Tier 1 - Typically Generic	$20 copay per prescription (retail) and $20 copay per prescription (home delivery)	Not covered
Tier 2 - Typically Preferred Brand	$40 copay per prescription (retail) and $80 copay per prescription (home delivery)	Not covered
Tier 3 - Typically Non-Preferred Brand	$80 copay per prescription (retail) and $160 copay per prescription (home delivery)	Not covered
Tier 4 - Typically Specialty (brand and generic)	25% coinsurance up to $150 min / $300 max per prescription (retail and home delivery)	Not covered

Notes:

- Dependent Age Limit: to the end of the year 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.
- ‡ You will pay your PCP or Specialist office visit copay for certain services provided in their office.
- 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.

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