Anthem BlueCross BlueShield

Individual and family health benefit plans for Indiana

Benefit Snapshot

Core, Essential and Preferred Plans

Benefit Snapshot

Below is a listing of our plan choices, including a sample of commonly used benefits and how they are covered under each plan. Each plan name has a unique four-letter code at the end. When filling out an application, make sure the entire plan name on the application (including the four letters) matches the plan you want to apply for.

If you need more information about a certain benefit that is not listed here, please check with your Anthem Blue Cross and Blue Shield (Anthem) authorized representative. You can also view and compare plans on anthem.com.

Plan Name	Network Name	Calendar Year Deductible		Calendar Year Out-of-pocket Limit		Office Visit: Primary Care Doctor	Preventive Care	Retail Prescription Drug Coverage			
		Individual	Family	Individual	Family			Tier 1	Tier 2	Tier 3	Tier 4
Anthem Core DirectAccess with HSA - cabp	Pathway	$4,000	$8,000	$6,350	$12,700	Deductible and 20% coinsurance applies	No cost to you	Deductible and 20% coinsurance applies	Deductible and 20% coinsurance applies	Deductible and 20% coinsurance applies	Deductible and 20% coinsurance applies
Anthem Core Direct Access with HSA- caap	Pathway	$6,000	$12,000	$6,350	$12,700	Deductible and 0% coinsurance applies	No cost to you	Deductible and 0% coinsurance applies	Deductible and 0% coinsurance applies	Deductible and 0% coinsurance applies	Deductible and 0% coinsurance applies
Anthem Core DirectAccess - caac	Pathway	$5,750	$11,500	$6,350	$12,700	$40 copay per visit for first 3 office visits, then deductible and 20% coinsurance applies. Other office services subject to deductible and 20% coinsurance.	No cost to you	$20 copay	$50 copay	Deductible and 20% coinsurance applies	Deductible and 20% coinsurance applies
Anthem Core DirectAccess with Child Dental - cdac	Pathway	$5,750	$11,500	$6,350	$12,700	$40 copay per visit for first 3 office visits, then deductible and 20% coinsurance applies. Other office services subject to deductible and 20% coinsurance.	No cost to you	$20 copay	$50 copay	Deductible and 20% coinsurance applies	Deductible and 20% coinsurance applies
Anthem Core DirectAccess - caal	Pathway	$5,550	$11,100	$6,350	$12,700	$45 copay per visit for first 3 office visits, then deductible and 25% coinsurance applies. Other office services subject to deductible and 25% coinsurance.	No cost to you	$20 copay	$50 copay	Deductible and 25% coinsurance applies	Deductible and 25% coinsurance applies
[1]Anthem Core DirectAccess - cacb	Pathway	$5,000	$10,000	$6,350	$12,700	$50 copay per visit for first 3 office visits, then deductible and 40% coinsurance applies. Other office services subject to deductible and 40% coinsurance.	No cost to you	Deductible and 40% coinsurance applies	Deductible and 40% coinsurance applies	Deductible and 40% coinsurance applies	Deductible and 40% coinsurance applies
Anthem Essential DirectAccess - cbei	Pathway	$2,500	$5,000	$6,000	$12,000	$30 copay per visit, other office services subject to deductible and 10% coinsurance.	No cost to you	$15 copay	$40 copay	Deductible and 10% coinsurance applies	Deductible and 10% coinsurance applies
Anthem Essential DirectAccess with HSA - cbfg	Pathway	$2,500	$5,000	$4,000	$8,000	Deductible and 10% coinsurance applies	No cost to you	Deductible and 10% coinsurance applies	Deductible and 10% coinsurance applies	Deductible and 10% coinsurance applies	Deductible and 10% coinsurance applies
Anthem Essential DirectAccess - cbjc	Pathway	$1,750	$3,500	$6,350	$12,700	$35 copay per visit for first 3 office visits, then deductible and 20% coinsurance applies. Other office services subject to deductible and 20% coinsurance.	No cost to you	$15 copay	$40 copay	Deductible and 20% coinsurance applies	Deductible and 20% coinsurance applies
Anthem Essential DirectAccess - cbam	Pathway	$2,850	$5,700	$6,350	$12,700	$30 copay per visit, other office services subject to deductible and 15% coinsurance.	No cost to you	$15 copay	$40 copay	Deductible and 15% coinsurance applies	Deductible and 15% coinsurance applies
Anthem Preferred DirectAccess - ccaf	Pathway	$1,000	$2,000	$3,500	$7,000	$30 copay per visit, other office services subject to deductible and 10% coinsurance.	No cost to you	$15 copay	$40 copay	Deductible and 10% coinsurance applies	Deductible and 10% coinsurance applies
Anthem Preferred DirectAccess with Child Dental - cdct	Pathway	$1,000	$2,000	$3,500	$7,000	$30 copay per visit, other office services subject to deductible and 10% coinsurance.	No cost to you	$15 copay	$40 copay	Deductible and 10% coinsurance applies	Deductible and 10% coinsurance applies

[1]This plan also includes out-of-network benefits.

Preventive care services consist of services recommended by the United States Preventive Services Task Force, including well-child care, immunizations, PSA screenings, Pap tests, mammograms and more.

Anthem BlueCross BlueShield

Get help today!

Call your Anthem authorized representative or visit us online at anthem.com where you can view and compare plan options.

This document is only a brief summary of benefits and services. Our plans have exclusions, limitations and terms under which the contract may be continued in force or discontinued. For more complete details including what's covered and what isn't:

- See the coverage details document included with this brochure.
- Call your Anthem authorized representative.
- Go to anthem.com.

For more information on how to access a Summary of Benefits and Coverage (SBC), please visit www.healthcare.gov and enter SBC in the search field.

The health plans described within this document are not eligible for a premium tax credit subsidy.

Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc. Independent licensee of the Blue Cross and Blue Shield Association. ®ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

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Coverage Details for Indiana

Anthem BlueCross BlueShield

Things you need to know before you buy...

Anthem Core DirectAccess, Anthem Core DirectAccess with Child Dental, Anthem Core DirectAccess with HSA, Anthem Essential DirectAccess, Anthem Essential DirectAccess with HSA, Anthem Preferred DirectAccess, Anthem Preferred DirectAccess with Child Dental, Anthem Catastrophic DirectAccess

Before choosing a health benefit plan, please review the following information along with the other materials enclosed.

Eligibility

Subscriber

To be eligible for membership as a subscriber, the applicant must:

1. Be a United States citizen or national; or
2. Be a lawfully present non-citizen for the entire period for which coverage is sought; and
3. Be a legal resident of the State of Indiana
4. Be under age 65;
5. Submit proof satisfactory to Anthem to confirm dependent eligibility;
6. Agree to pay for the cost of premium that Anthem requires;
7. Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or dependents as they become effective;
8. Not be incarcerated (except pending disposition of charges);
9. Not be entitled to or enrolled in Medicare;
10. Not be covered by any other group or individual health benefit plan.

For purposes of eligibility, the service area is the area in which you:

1. Reside, intend to reside (including without a fixed address); or
2. The area in which you are seeking employment (whether or not currently employed); or
3. Have entered without a job commitment.

Dependents

To be eligible for coverage to enroll as a dependent, you must be listed on the enrollment form completed by the subscriber, meet all dependent eligibility criteria and be:

1. The subscriber's legal spouse.
2. The subscriber's domestic partner. Domestic partner, or domestic partnership means a person of the same or opposite sex for whom all of the following are true: he or she is the subscriber's sole domestic partner and has been for twelve (12) months or more; he or she is mentally competent; neither the subscriber nor the domestic partner is related in any way (including by adoption or blood) that would prohibit him or her from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with the subscriber.
   a. For purposes of your Contract, a domestic partner shall be treated the same as a spouse, and a domestic partner's child, adopted child, or child for whom a domestic partner has legal guardianship shall be treated the same as any other child.
   b. A domestic partner's or a domestic partner's child's coverage ends on the date of dissolution of the domestic partnership.
   c. To apply for coverage as domestic partners, both the subscriber and the eligible domestic partner are required to complete and sign an enrollment application, meet all criteria stated in the enrollment application and submit the enrollment application to Anthem. We reserve the right to make the ultimate decision in determining eligibility of the domestic partner.
3. The subscriber's or the subscriber's spouse's children, including natural children, stepchildren, newborn and legally adopted children under age 26.
4. Children for whom the subscriber or the subscriber's spouse is a legal guardian under age 26.

Eligibility will be continued past the age limit only for those already enrolled dependents who cannot work to support themselves by reason of intellectual or physical disability. These dependents must be allowed as a federal tax exemption by the subscriber or subscriber's spouse. The dependent's disability must start before the end of the period he or she would become ineligible for coverage. The Plan must certify the dependent's eligibility. The Plan must be informed of the dependent's eligibility for continuation of coverage within 31 days after the dependent would normally become ineligible. You must notify Anthem if the dependent's tax exemption status changes and if he or she is no longer eligible for continued coverage.

The Plan may require the subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

Temporary custody is not sufficient to establish eligibility under your Contract.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under your Contract unless required by the laws of this state.

Open Enrollment

An annual open enrollment period is provided for enrollees. Individuals may enroll in a plan, and members may change plans at that time.

Changes Affecting Eligibility and Special Enrollment

A special enrollment period is a period during which a member or an enrollee who experiences certain qualifying events or changes in eligibility may enroll in a plan, outside of the annual open enrollment period.

Length of special enrollment periods: Unless specifically stated otherwise, a member or enrollee has 60 calendar days from the date of a qualifying event to select a plan.

Qualifying Events:

- Involuntary loss of minimum essential coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay premium;
- Loss of minimum essential coverage due to dissolution of marriage;
- Marriage;
- Adoption or placement for adoption; and
- Birth.

Newborn and Adopted Child Coverage

Newborn children of the subscriber or the subscriber's spouse will be covered for an initial period of 31 days from the date of birth. Coverage for newborns will continue beyond the 31 days, provided the subscriber with other than family coverage submits through the Plan a form to add the child under the subscriber's Contract. The form must be submitted along with the additional premium, if applicable, within 60 days after the birth of the child. A child will be considered adopted from the earlier of: (1) the moment of placement for adoption; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Adding a Child due to Award of Guardianship

If a subscriber or the subscriber's spouse files an application for an appointment of guardianship for a child, an application to cover the child under the subscriber's Contract must be submitted to us within 60 days of the date of the appointment of guardianship. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

Qualified Medical Child Support Order

If you are required by a Qualified Medical Child Support Order or court order, as defined by applicable state or federal law, to enroll your child under your Contract, and the child is otherwise eligible for the coverage, we will permit your child to enroll under your Contract, and we will provide the benefits of your Contract in accordance with the applicable requirements of such order.

A child's coverage under this provision will not extend beyond any dependent age limit listed in the summary of cost shares and benefits. Any claims payable under your Contract will be paid, at Anthem's discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to us directly.

Effective Date of Coverage

Effective date for the annual open enrollment period is the first day of the following month if receipt of application is between the 1st and 15th of the month. If receipt of application is after the 15th of the month, your effective date will be the first day of the month following plus one additional month (example: application receipt is January 20, your effective date is March 1).

Effective dates for special enrollment periods:

1. In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption; and
2. In the case of marriage, or in the case where an individual loses minimum essential coverage, coverage is effective on the first day of the following month after your application is received.

Effective dates for special enrollment due to loss of minimum essential coverage apply when the loss of minimum essential coverage includes loss of eligibility for coverage as a result of:

1. Legal separation or divorce;
2. Cessation of dependent status, such as attaining the maximum age;
3. Death of an employee;
4. Termination of employment;
5. Reduction in the number of hours of employment; or
6. Any loss of eligibility for coverage that is measured by reference to any of the foregoing;
   - Individual who no longer resides, lives or works in the Plan's service area,
   - A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
   - Termination of employer contributions, and
   - Exhaustion of COBRA benefits.

Effective dates for loss of minimum essential coverage does not include termination or loss due to:

1. Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or
2. Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Guaranteed Renewable

Coverage under your Contract is guaranteed renewable at the discretion of the member. The member may renew the Contract by payment of the renewal Premium by the end of the grace period of the premium due date, provided the following requirements are satisfied:

1. Eligibility criteria continues to be met;
2. There are no fraudulent or intentional material misrepresentations of material fact on the application or under the terms of this coverage;
3. Membership has not been terminated by Anthem under the terms of your Contract; and
4. Membership has not been rescinded by Anthem.

Network Services and Providers

Note: Services will only be covered services if rendered by providers located in Indiana unless:

- **The services are for emergency care, urgent care and ambulance services; or**
- **The services are approved in advance by Anthem.**

If your care is rendered by a primary care physician (PCP), specialty care physician (SCP), or another network provider, benefits will be provided at the network level. Regardless of medical necessity, no benefits will be provided for care that is not a covered service even if performed by a PCP, SCP or another network provider. All medical care must be under the direction of physicians. We have final authority to determine the medical necessity of the service or referral to be arranged. We may inform you that it is not medically necessary for you to receive services or remain in a hospital or other facility. This decision is made upon review of your condition and treatment. You may appeal this decision.

In-network providers include PCPs, SCPs, other professional providers, hospitals and other facility providers who contract with Anthem to perform services for you. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatricians or other in-network providers as allowed by the Plan. The PCP is the physician who may provide, coordinate and arrange your health care services. SCPs are network physicians who provide specialty medical services not normally provided by a PCP.

A consultation with an in-network health care provider for a second opinion may be obtained at the same copayment/coinsurance as any other service.

For services rendered by in-network providers:

- You will not be required to file any claims for services you obtain directly from in-network providers. In-network providers will seek compensation for covered services rendered from Anthem and not from you except for approved copayments/coinsurance and/or deductibles. You may be billed by your in-network provider(s) for any non-covered services you receive or where you have not acted in accordance with your Contract.
- Health Care Management is the responsibility of the in-network provider.

If there is no in-network provider who is qualified to perform the treatment you require, contact Anthem prior to receiving the service or treatment and Anthem may approve a non-network provider for that service as an authorized service.

Non-Network Services (with the exception of Anthem Core DirectAccess – cacb)

Your health care plan does not cover benefits for services received from non-network providers unless the services are:

- To treat an emergency medical condition;
- Out-of-area urgent care; or
- Authorized by Anthem.

Non-Network Providers (Anthem Core DirectAccess – cacb only)

Note: Services will only be covered services if rendered by providers located in Indiana unless:

- **The services are for emergency care, urgent care and ambulance services; or**
- **The services are approved in advance by Anthem.**

Covered services which are not obtained from a PCP, SCP or another in-network provider or not an authorized service will be considered a non-network service. The only exceptions are emergency care and urgent care. In addition, certain services are not covered unless obtained from an in-network provider. See your Summary of Cost Shares and Benefits.

For services rendered by a non-network provider, you are responsible for:

- The difference between the actual charge and the maximum allowed amount plus any deductible and/or copayments/coinsurance;
- Services that are not medically necessary;
- Non-covered services;
- Filing claims;
- Higher cost-sharing amounts

How to Find a Provider in the Network

There are three ways you can find out if a provider or facility is in the network for one of these plans. You can also find out where they are located and details about their license or training.

- See your Plan's directory of in-network providers at anthem.com, which lists the doctors, providers, and facilities that participate in this Plan's network.

- Call Customer Service to ask for a list of doctors and providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your doctor or provider.

If you need help choosing a doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

Requesting Approval for Benefits

Your Contract includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered services must be medically necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be medically necessary if they are given in a higher cost setting.

Your Contract includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered services must be medically necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be medically necessary if they are given in a higher cost setting

Prior Authorization: Network providers must obtain Prior Authorization in order for you to get benefits for certain services. Prior Authorization criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. Anthem may decide that a service that was first prescribed or asked for is not medically necessary if you have not first tried other medically necessary and more cost-effective treatments.

If you have any questions about the information in this section, you may call the Customer Service phone number on the back of your Member Identification Card.

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor/childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.
- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. Anthem will check your Contract to find out if there is an exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of medical necessity under your Contract, or is experimental/investigative as that term is defined in your Contract.
- **Post Service Clinical Claims Review** – A Retrospective review for a benefit coverage determination to decide the medical necessity or experimental/investigative nature of a service, treatment or admission that did not need Precertification and did not have a predetermination review performed. Medical reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

Typically, in-network providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your primary care physician and other in-network providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering provider, facility or attending doctor will get in touch with us to ask for a Precertification or Predetermination review ("requesting provider"). We will work with the requesting provider for the Precertification request. However, you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Your Rights and Responsibilities

As a member, you have certain rights and responsibilities to help make sure that you get the most from this Plan. It helps you know what you can expect from your overall health care benefit experience and become a smarter health care consumer.

You have the right to:

- Speak freely and privately with your doctors and other health professionals about all health care options and treatment needed for your condition, no matter what the cost or whether it is covered under your Plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect and dignity.
- Privacy of your personal health information, as long as it follows State and Federal laws and our privacy policies.
- Get information about our company and services, and our network of doctors and other health care providers.
- Get more information about your Rights and Responsibilities and give us your thoughts and ideas about them.

- Give us your thoughts and ideas about any of the rules of your Plan and in the way it works.
- Make complaints or appeal about: our organization, any benefit or coverage decisions we make, your coverage, or care received.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future; and the right to have your doctor tell you how that may affect your health now and in the future.
- Get up-to-date information about the cause of your illness, your treatment and what may result from that illness or treatment from a doctor or other health care professional. When it seems that you will not be able to understand certain information, that information will be given to someone else that you choose.

You have the responsibility to:

- Choose an in-network primary care physician (doctor), also called a PCP, if your Plan requires it.
- Treat all doctors, health care professionals and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers and call their office if you have a delay or need to cancel.
- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- To the extent possible, understand your health problems and work with your doctors or other health care professionals to make a treatment plan that you all agree on.
- Give Anthem, your doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health coverage and insurance benefits you have in addition to your coverage with us.
- Tell your doctors or other health care professionals if you don't understand any care you are getting or what they want you to do as part of your care plan.
- Follow the care plan that you have agreed on with your doctors and other health care professionals.
- Follow all Plan rules and policies.
- Let our customer service department know if you have any changes to your name, address or dependents covered under your Plan.

Exclusions and Limitations

Please see your Contract for details.

Selecting health coverage is an important decision.

To assist you, we supply the following for the plans under consideration: Brochure, Benefit Snapshot, Coverage Details and Enrollment Application. If you did not receive one or more of these materials, please contact your Anthem authorized representative to request them.

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