Indiana State Medical Association Group Health Insurance

HSA 3000/6000

		Blue Access (PPO) Network	Out of Network
Office Visit		Deductible/coinsurance	Deductible/coinsurance
Preventive Care (includes vision screening test)		Covered in full	Deductible/coinsurance
Urgent Care		Deductible/coinsurance	Deductible/coinsurance
Emergency Room		Deductible/coinsurance	Deductible/coinsurance
Rx Drugs *covered after annual plan deductible is met	- 30 day supply	* $15 generic / $40 formulary / $80 non-formulary/ 25% to $200 max. specialty	Deductible/coinsurance
	- 90 day mail order	* $38 generic / $120 formulary / $240 non-formulary/ 25% to $200 max. specialty	Not covered
Deductible (calendar year)	- Per person per calendar year	$3,000	$3,000
	- Maximum per family per calendar year	$6,000	$6,000
Coinsurance		100% / 0%	50% / 50%
Out of Pocket Maximum (calendar year)	- Per person per calendar year	$4,500	$6,000
	- Maximum per family per calendar year	$9,000	$12,000
Maximum Benefit per person per lifetime			Unlimited

Covered Benefits

- Preventive Care: Includes all services coded as preventive.
- Physician Office Services: Includes office visits, office surgeries, preconception care & education, allergy testing and treatment - serum and injections.
- LiveHealth Online: Online physician visits, subject to Office Visit Copay.
- Urgent Care Facility Services
- Emergency Room Facility Services
- Prescription Drugs: Includes oral contraceptives.
- Inpatient Hospital Care: Unlimited number of days of semi-private room or ward accommodations and other necessary services not included in the room charges.
- In-hospital Medical Care: Visits by your doctors
- Diagnostic X-rays and Lab Tests
- Surgery
- Anesthesia
- Consultation: Inpatient or outpatient consultations
- Radiation Therapy: Treatment of abnormal growths by radiation (inpatient or outpatient basis).
- Mental Health/Substance Abuse
- Maternity: Benefits paid same as for any illness.
- Infertility: $5,000 lifetime maximum benefit per person for treatment of infertility.
- Outpatient Therapy: Physical/occupational therapy 60 visits per calendar year; Speech therapy 20 visits per calendar year; Spinal manipulation 12 visits per calendar year, 36 cardiac rehabilitation visits per calendar year and 20 pulmonary rehabilitation visits per calendar year.
- Skilled Nursing Facility: 90 days per calendar year combined Network and Non Network.
- Approved Home Health Care Services: 100 visits per calendar year.
- Private Duty Nursing: 82 visits per calendar year combined Network and Non Network; 164 visits per lifetime combined Network and Non Network.
- Medical Supplies, Equipment and Appliances: Subject to deductible and coinsurance.
- Temporomandibular Joint (TMJ) Services: Benefits paid same as for any illness.
- Hospice Services
- Foreign Travel: Same benefits paid in or outside the U.S.
- Human Organ or Tissue Transplant: Covers these human to human organ and tissue transplants: bone marrow, heart, heart/lung, lung, liver, pancreas and kidney/pancreas. In network covered in full; out of network 50% coinsurance. Kidney and cornea transplants covered under health benefit.
- Benefit Management Program: In catastrophic/chronic cases, alternative means of care may be offered, subject to approval of the insured and the attending physician, i.e., skilled nursing facility, home health care, hospice care or special medical equipment such as ventilators and respirators.
- Mandatory Precertification on Inpatient and Selected Outpatient Services with Noncompliance Penalty: Inpatient, 30% penalty. Outpatient, precertification not required.
- BlueCard Program: In many cases, when you travel or live outside your Blue Cross and Blue Shield Plan's service area, you can take advantage of savings the local Blue Plan has negotiated with doctors and hospitals in the area. You should not have to pay any amount above these negotiated rates. Also, you should not have to complete a claim form or pay up front for your health care services, except for those out-of-pocket expenses (like non-covered services, deductible, copay, and coinsurance) that you'd pay anyway. More than 85 percent of all doctors and hospitals throughout the U.S. contract with Blue Cross and Blue Shield Plans. Outside of the U.S., you have access to doctors and hospitals in more than 200 countries. Always use a BlueCard PPO doctor or hospital to make sure you receive the highest level of benefits. Visit the BlueCard Doctor and Hospital Finder Web site (www.anthem.com) or call BlueCard Access at 1-800-810-BLUE to locate doctors and hospitals when you need care outside of your Blue Plan's service area.

Exclusions

Services not covered under the Medical Plans include:

- Services or supplies not medically necessary
- Cosmetic surgery
- Dental care not caused by an accident unless you are covered under the Dental Plan
- Eyeglasses or hearing aids
- Services covered by worker's compensation

Complete list of exclusions printed in Certificate of Coverage.

Limitations

Unless otherwise noted, covered charges are eligible up to the usual, customary and reasonable allowance, which is measured and determined by comparing actual provider charges with charges customarily made for similar services and supplies for individuals with similar medical conditions.

This is not meant as a replacement to the Certificate of Coverage and whenever a discrepancy exists between the Certificate of Coverage and this brochure, the Certificate of Coverage will govern the administration of the plan. Effective 7/1/2017 for July renewals, 10/1/2017 for October renewals, 1/1/2018 for January renewals and 4/1/2018 for April renewals.