

Your Anthem Benefits



Fort Wayne Community Schools Anthem Blue AccessSM Network (PPO) Buy-Up Plan (HP1) Summary of Benefits, Effective January 1, 2017

Please Note: As we receive additional guidance and clarification from the U.S. Department of Health and Human Services, we may be required to make additional changes to your benefits.

COVERED BENEFITS	NETWORK/NON-NETWORK (MEMBER'S RESPONSIBILITY)
Deductible (Single/Family) <i>(Applies only to percent (%) copayments)</i>	\$100/\$200 Network/Non-network combined
Out-of-Pocket Maximum (Single/Family)	\$350/\$700 Network/Non-network combined
Office Services • Including Allergy – testing and treatment – serum and injections	10% Network/20% Non-network Per Visit
Preventive Care	No copayment/coinsurance. network / 20% Non-network For Preventative Benefits please see Plan Certificate.
Maternity Services	10% Network/20% Non-network
TMJ Services	10% Network/20% Non-network
Inpatient Services	10% Network/20% Non-network per admission
Outpatient Facility Services	10% Network/20% Non-network
Professional/Home Care (Inpatient/Outpatient)	10% Network/20% Non-network Home care – unlimited visits
Emergency and Urgent Care:	
Emergency Care in ER Room <i>(covers all services, waived if admitted)</i>	10% Network/Non-network
Urgent Care Facility	10% Network/Non-network
Hospice	Covered in full Network or Non-network
Ambulance	10% Network 10% Non-network
Medical Supplies, Equipment and Appliances	10% Network/20% Non-network
Outpatient Therapy Visit Limits <i>(Limits apply to Network/Non-network combined visits.)</i>	
Physical/Occupational	Unlimited Network and Non-network combined visits; same copay as office services
Spinal Manipulation	24 Network and Non-network combined visits; same copay as office services
Speech	Unlimited Network and Non-network combined visits; same copay as office services
Mental Health and Substance Abuse	
• Inpatient Facility Services	10% network/20% non-network
• Inpatient Professional Services	10% network/20% non-network
• Physician Home and Office Visits (PCP/SCP)	No cost share or deductible network/ non-network
• Other Outpatient Services, Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional	No cost share or deductible network/ non-network
Lifetime Maximum	UNLIMITED
Human Organ and Tissue Transplants	Covered in full Network/50% Non-network (Does not count toward out-of-pocket maximum)

Prescription Drug Options:	Network	Non-network
Network Retail Pharmacies: (30-day supply)	\$10 formulary generic*/\$20 formulary brand \$30 non-formulary generic/brand	50% Non-network
Anthem Rx Direct Mail Service: (90-day supply)	\$20 formulary generic*/\$40 formulary brand \$60 non-formulary generic/brand	Not covered Non-network
Refill by Mail Program	Out of Pocket Limit :\$4,500 Single/\$9,000 Family	
	*Single Source drugs have the generic copayment.	

Notes:

- *The medical and prescription drug deductibles and copayments (except human organ and tissue transplants, excluding kidney and cornea) apply toward the out-of-pocket maximums.*
- *The deductible(s) apply only to covered services listed with a percentage (%) copayment.*
- *Network and Non-network deductibles and out-of-pocket maximums are not separate and do accumulate toward each other.*
- *Network and Non-network copayments do accumulate toward each other.*
- *Dependent age: to the end of the month which child attains age 26.*
- *Certain diabetic and asthmatic supplies are covered in full at network pharmacies.*
- *Office services also include- office surgeries and preconception care/education.*

Precertification:

Members are encouraged to always obtain prior approval when using Non-network providers. Precertification will avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.

Benefit information contained herein is not final, pending approval of the Indiana Dept. of Insurance.