Below is a comparison of the essential health insurance benefits required of individual health insurance coverage regulated by the State of Illinois and the benefits covered under your health insurance plan. This information is furnished pursuant to the Illinois Consumer Coverage Disclosure Act. This disclosure does not change or replace the language contained in your Certificate of Coverage which sets forth your health insurance benefits.

Name of Issuer:	**Anthem Blue Cross and Blue Shield - IN**
Plan Marketing Name:	**PPO/HSA plans**
Plan Year:	**2024-2025**

Ten (10) Essential Health Benefit (EHB) Categories:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

2020-2024 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)

Item	EHB Benefit	EHB Category	Benchmark Page # Reference	ADP TotalSource Plan Covered Benefit
1	Accidental Injury -- Dental	Ambulatory	Pgs. 10 & 17	Covered*
	*Notes: Benefits are also available for dental work needed to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident. An injury that results from chewing or biting is not considered an Accidental Injury under this Plan, unless the chewing or biting results from a medical or mental condition. Treatment must begin within 12 months of the injury, or as soon after that as possible to be a Covered Service under this Plan.			
2	Allergy Injections and Testing	Ambulatory	Pg. 11	Covered*
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	Not Covered
4	Durable Medical Equipment	Ambulatory	Pg. 13	Covered*
5	Hospice	Ambulatory	Pg. 28	Covered*

	*Notes: You are eligible for hospice care if your Physician and the Hospice medical director certify that you are terminally ill and likely have less than twelve (12) months to live.			
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23 - 24	See notes*
	*Important Note: Although this Plan offers limited coverage of certain infertility services, it does not cover all forms of infertility treatment. Benefits do not include assisted reproductive technologies (ART) or the diagnostic tests and Drugs to support it. Examples of ART include artificial insemination, in-vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT). Covered Services include diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis. Benefits also include services to treat the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency). Fertility treatments such as artificial insemination and in-vitro fertilization are not a Covered Service.			
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	Covered
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15 - 16	Covered
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	Covered (In home care setting)
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	Covered
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	Covered *
	Notes: Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered.			
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	Covered *
	Notes: Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).			
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	Covered
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	Covered
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	Not Covered
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24 - 25	Covered
17	Reconstructive Surgery	Hospitalization	Pgs. 25 - 26, & 35	Covered *

*Notes: Benefits include reconstructive surgery to correct deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan.				
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	Covered
19	Skilled Nursing Facility	Hospitalization	Pg. 21	Covered *
*Notes: Coverage for Skilled Nursing, Outpatient Rehabilitation and Inpatient Rehabilitation facility settings is limited to 150 days combined per benefit period.				
20	Transplants - Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	Covered
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Covered
22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	Covered
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8 -9, 21	Covered
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	Covered
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	Covered
26	Tele-Psychiatry	MH/SUD	Pg. 11	Covered
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	Covered
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	Not Covered
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26 - 27	Not Covered
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Covered
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29 - 34	Covered
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Covered
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Covered
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	Covered
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31 - 32	Covered
36	Mammography - Screening	Preventive and Wellness Services	Pgs. 12, 15, & 24	Covered
37	Osteoporosis - Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	Covered
38	Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Covered

39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	Covered
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Covered
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12 - 13	Covered *
				*Notes: Manipulation Therapy Coverage is limited to 12 visits per benefit period.
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22, & 35	Covered

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.