H&R Block Plus Plan - 2021

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For additional information on this plan summary, please call the H&R Block service center at Anthem BlueCross BlueShield at : 1-866-510-4736		
	IN-NETWORK[1]	**OUT-OF-NETWORK[2]**
COST SHARING		
Annual Deductible	Individual $1,500 Family $3,000	Individual $3,000 Family $6,000
Plan Coinsurance (unless indicated otherwise)	85%	50%
Copayments	Primary N/A Specialist N/A Emergency Room N/A	Primary N/A Specialist N/A Emergency Room N/A
Out-of-Pocket maximum (Includes Deductible)	Individual $3,000 Family $6,000	Individual $6,000 Family $12,000
Individual Out-of-Pocket maximum (Includes Deductible)	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.	
Lifetime maximum	Unlimited	
Dependent Children	Eligible dependents are covered until the end of the month in which they turn 26.	
HOSPITAL BENEFITS		
Inpatient[3] Precertification is required	Covered At 85% Deductible Yes	Covered At 50% Deductible Yes
Inpatient Mental Health Benefits[3]: Precertification is required	Covered At 85% Deductible Yes	Covered At 50% Deductible Yes
Inpatient Substance Abuse and Detox benefits[3]: Precertification is required	Covered At 85% Deductible Yes	Covered At 50% Deductible Yes
Outpatient/Facility [3] Ambulatory surgery Some services may require Pre-certification	Covered At 85% Deductible Yes	Covered At 50% Deductible Yes
Emergency Room/Facility[4] Covered for Medical Emergency only	Covered At 85% Deductible Yes	Covered At 85% Deductible Yes
OTHER FACILITY BENEFITS		
Home Health Care:[3] Limited to 120 visits per calendar year, combined In and out of Network. Home IV Therapy visits are not counted toward the maximum. Precertification is required	Covered At 85% Deductible Yes	Covered At 50% Deductible Yes
Hospice[3] Precertification is required	Covered At 85% Deductible Yes	Covered At 50% Deductible Yes
Skilled Nursing Facility[3] Limited to 60 days per calendar year, combined In and Out of Network Precertification is required	Covered At 85% Deductible Yes	Covered At 50% Deductible Yes
INSTITUTIONAL (outpatient) AND PROFESSIONAL (any setting) CARE		
Alcohol/Substance Abuse Treatment and Detox Intensive Outpatient services are covered subject to deductible and coinsurance	Covered At 85% Deductible Yes	Covered At 50% Deductible Yes
Mental Health Outpatient (inst. & prof.) Intensive Outpatient services are covered subject to deductible and coinsurance	Covered At 85% Deductible Yes	Covered At 50% Deductible Yes
Occupational Therapy: Limited to 60 visits per calendar year (combined Physical, Occupational and Speech Therapy). Professional and institutional combined; combined In and Out of Network. **Additional visits may be received and are subject to medical necessity guidelines. There must be signs of significant progress.**	Covered At 85% Deductible Yes	Covered At 50% Deductible Yes
Physical Therapy: Limited to 60 visits per calendar year (combined Physical, Occupational and Speech Therapy). Professional and institutional combined; combined In and Out of Network. **Additional visits may be received and are subject to medical necessity guidelines. There must be signs of significant progress.**	Covered At 85% Deductible Yes	Covered At 50% Deductible Yes
Speech Therapy Limited to 60 visits per calendar year (combined Physical, Occupational and Speech Therapy). Professional and institutional combined; combined In and Out of Network. **Additional visits may be received and are subject to medical necessity guidelines. There must be signs of significant progress.**	Covered At 85% Deductible Yes	Covered At 50% Deductible Yes
X-Rays and Lab Tests (Non-routine)	Covered At 85% Deductible Yes	Covered At 50% Deductible Yes

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	IN-NETWORK[1]	OUT-OF-NETWORK[2]
MEDICAL BENEFITS		
Air and Ground Ambulance Must be medically necessary to be covered	Covered At 85% Deductible Yes	Covered At 85% Deductible Yes
Allergy Care	Covered At 85% Deductible Yes	Covered At 50% Deductible Yes
Chiropractic Care Limited to 20 visits per calendar year. Combined In and Out of Network. Maximum includes all services billed by a chiropractor. Chiropractic and Therapy maximums are not combined.	Covered At 85% Deductible Yes	Covered At 50% Deductible Yes
Durable Medical Equipment Diabetic supplies are covered and paid at the In Network level. Replacements only covered once every 3 calendar years. DME and Rentals over $1000 require pre-certification TMJ appliances are not covered Wigs/Toupees are covered up to $750/calendar year. Covered when necessitated by disease or permanent loss of scalp hair due to injury , does not include wig maintenance or prescriptions or medications related to hair growth.	Covered At 85% Deductible Yes	Covered At 50% Deductible Yes
Exams - Routine Adult Physical The following Women's Preventive Services are covered at 100%: Breastfeeding support and supplies; counseling and contraceptive counseling	Covered At 100% Deductible No	Covered At 50% Deductible Yes
Exams - Routine Well Child Care	Covered At 100% Deductible No	Covered At 50% Deductible Yes
Immunizations (routine)	Covered At 100% Deductible No	Covered At 50% Deductible Yes
Mammography (routine) No limit per calendar year on routine mammogram	Covered At 100% Deductible No	Covered At 50% Deductible Yes
Maternity Care (professional charge) Dependent daughters are covered.	Covered At 85% Deductible Yes	Covered At 50% Deductible Yes
Transplant Services[3,4] Precertification is required	Covered At 85% Deductible Yes	Not Covered
Surgery Cosmetic Reconstructive Surgery (subject to medical necessity) Sterilization (Reversal of Sterilization is not Covered) Precertification is required	Covered At 85% Deductible Yes	Covered At 50% Deductible Yes
Live Health Online (Online Visits)	Covered At 100% Deductible No	Not Covered
Telehealth – Consultation with your physician (PCP/Specialist) using visual and audio (Computer, Smart Phone, Tablet)	Covered At 85% Deductible Yes	Covered At 50% Deductible Yes
Telephonic – Consultation with your physician (PCP/Specialist) using audio only (Telephone)	Covered At 85% Deductible Yes	Covered At 50% Deductible Yes
PHARMACY BENEFITS - Retail and Mail Order (Mail Order is IN-NETWORK only)		
Preventive drugs	Covered At 85% Deductible No	Covered At 85% Deductible No
All Other Pharmacy (excluding preventive drugs)	Covered At 85% Deductible Yes	Covered At 85% Deductible Yes
The following Women's Preventive Services are covered at 100%: FDA approved birth control that require a prescription.	Covered At 100% Deductible No	Covered At 100% Deductible No

[1]Network provider delivers care.

[2]Out-of-network services are those from a provider that does not participate with Anthem or with another Blue Cross and Blue Shield Plan through the BlueCard PPO Program. (This does not apply to emergency benefits.) Out-of-network services are subject to balance billing over allowed amount.

[3]Precertification by Anthem's Medical Management is required. If not obtained, penalties will apply.

[4] Anthem's Medical Management Program must be notified within 24/48 hours in the event of an emergency admission.

NOTE: This is a benefit summary only and is subject to the terms, conditions, limitations, and exclusions set forth in more detail in your group health plan documents. The benefit summary is not a contract or guarantee of coverage and in the event of any discrepancy between the benefit summary and your group health plan documents, your group health plan documents will control. Benefits are available for covered services that are medically necessary. To qualify for benefits, patients must be eligible at the time of service.