Your summary of benefits

Anthem®

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access PPO Plan 3 Hoosier School Benefit Trust

Your Network: Blue Access Effective: 01/01/2023

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$2,700 person / $5,400 family	$5,000 person / $10,000 family
Overall Out-of-Pocket Limit	$6,000 person / $10,000 family	$12,000 person / $20,000 family
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit. Your copays, coinsurance and deductible count toward your out of pocket limit(s). In-Network and Non-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Medical Chats and Virtual Visits for Primary Care *from our Online Provider K Health, through its affiliated Provider groups are covered at $0 copay per visit medical deductible does not apply.*		
Virtual Visits from online provider LiveHealth Online *for urgent/acute medical and mental health and substance abuse care via www.livehealthonline.com are covered at $40 copay per visit medical deductible does not apply.*		
Primary Care (PCP) and Mental Health and Substance Abuse Care *virtual and office*	$40 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Specialist Care *virtual and office*	$60 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$40 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Manipulation Therapy *Coverage is limited to 24 visits per benefit period.*	$40 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Other Services in an Office		
Allergy Testing *When Allergy injections are billed separately by network providers, the member is responsible for a $0 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Prescription Drugs *Dispensed in the office*	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Surgery	$60 copay per visit medical deductible does not apply‡	50% coinsurance after medical deductible is met
Preventive care / screenings / immunizations	No charge	50% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	50% coinsurance after medical deductible is met
Diagnostic Services **Lab**		
Office	No charge	50% coinsurance after medical deductible is met
Freestanding Lab/Reference Lab	No charge	50% coinsurance after medical deductible is met
Outpatient Hospital	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
X-Ray		
Office	No charge	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Freestanding Radiology Center	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Hospital	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	$100 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$250 copay per visit medical deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	Covered as In-Network
Ambulance	30% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse Care at a Facility		
Facility Fees	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Doctor Services	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Ambulatory Surgical Center	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Doctor and Other Services		
Hospital	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Ambulatory Surgical Center	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Human Organ and Tissue Transplants *Cornea transplants are treated the same as any other illness and subject to the medical benefits.*	No charge	50% coinsurance after medical deductible is met
Physician and other services *including surgeon fees*	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Home Health Care *Coverage is limited to 100 visits per benefit period.*	No charge	50% coinsurance after medical deductible is met
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for occupational therapy is unlimited visits per benefit period, physical therapy is unlimited visits per benefit period and speech therapy is unlimited visits per benefit period.*		
Office	$60 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Outpatient Hospital	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Pulmonary rehabilitation *Coverage is unlimited visits per benefit period.*		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Office	$60 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Outpatient Hospital	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Cardiac rehabilitation *Coverage is unlimited visits per benefit period.*		
Office	$60 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Outpatient Hospital	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Dialysis/Hemodialysis		
Office	No charge	50% coinsurance after medical deductible is met
Outpatient Hospital	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Chemo/Radiation Therapy		
Office	$60 copay per visit medical deductible does not apply‡	50% coinsurance after medical deductible is met
Outpatient Hospital	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Coverage for Skilled Nursing is limited to 60 days per benefit period.*	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Inpatient Hospice	No charge	No charge

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Durable Medical Equipment	30% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	30% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Notes:

- Dependent age: to end of the month in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- ‡ Your cost share will be reduced when services are provided in a PCP's office.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Your Plan: Anthem Blue Access PPO Option 14 with Rx Option T1

Your Network: Blue Access

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

Language Access Services:

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (833) 578-4441

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

(TTY/TDD: 711)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (833) 578-4441 .

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (833) 578-4441:

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French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (833) 578-4441.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (833) 578-4441.

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Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'idiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih ninízingo kojį' hodíilnih (833) 578-4441.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: (833) 578-4441.

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Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (833) 578-4441.

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Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (833) 578-4441.

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