Your summary of benefits

Anthem® Blue Cross and Blue Shield

Effective 1/1/2025

Hoosier School Benefit Trust

Your Plan: Anthem Blue Access PPO Plan 1-2

Your Network: Blue Access

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	$40 copay per visit medical deductible does not apply
Mental Health & Substance Use Disorder Services	$40 copay per visit medical deductible does not apply
Specialist care	$60 copay per visit medical deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	$1,500 person / $3,000 family	$3,000 person / $6,000 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. All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit. In-Network and Out-of-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).*		
Primary Care (PCP) and Mental Health and Substance Use Disorder Services *virtual and office*	$40 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Specialist Care *virtual and office*	$60 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Other Practitioner Visits		
Maternity Doctor services (prenatal/postnatal care and delivery)	30% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
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	40% 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	40% 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	40% coinsurance after medical deductible is met
Prescription Drugs *Dispensed in the office*	30% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Surgery	$60 copay per visit medical deductible does not apply‡	40% coinsurance after medical deductible is met
Preventive care / screenings / immunizations	No charge	40% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	40% coinsurance after medical deductible is met
Diagnostic Services		
Lab		
Office	No charge	40% coinsurance after medical deductible is met
Freestanding Lab/Reference Lab	No charge	40% coinsurance after medical deductible is met
Outpatient Hospital	30% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
X-Ray		
Office	No charge	40% coinsurance after medical deductible is met
Outpatient Hospital	30% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	30% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Freestanding Radiology Center	30% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	30% coinsurance after medical deductible is met	40% 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	40% coinsurance after medical deductible is met
Emergency Room Facility Services *Your copay will be 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 *Authorized Out-of-Network non-emergency ambulance services are limited to an Anthem maximum payment of $50,000 per trip.*	30% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	30% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Doctor Services	30% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Surgery		
Facility Fees		
Hospital	30% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Ambulatory Surgical Center	30% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Physician and other services *including surgeon fees*		
Hospital	30% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Ambulatory Surgical Center	30% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)		
Facility Fees	30% coinsurance after medical deductible is met	40% 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	40% coinsurance after medical deductible is met
Physician and other services *including surgeon fees*	30% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Home Health Care *Coverage is limited to 100 visits per benefit period* .	No Charge	40% coinsurance after medical deductible is met
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for physical and occupational therapies is unlimited visits per benefit period. Coverage for speech therapy is unlimited visits per benefit period.*		
Office	$60 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Hospital	30% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Pulmonary rehabilitation *Coverage is unlimited visits per benefit period.*		
Office	$60 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Outpatient Hospital	30% coinsurance after medical deductible is met	40% 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	40% coinsurance after medical deductible is met
Outpatient Hospital	30% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Dialysis/Hemodialysis		
Office	No charge	40% coinsurance after medical deductible is met
Outpatient Hospital	30% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Chemo/Radiation Therapy		
Office	$60 copay per visit medical deductible does not apply‡	40% coinsurance after medical deductible is met
Outpatient Hospital	30% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Skilled Nursing Care (facility) *Coverage for Skilled Nursing is limited to 60 days per benefit period*	30% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Inpatient Hospice	No charge	No charge
Durable Medical Equipment	30% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Notes:

- Dependent Age Limit: to the end of the month in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using Out-of-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 an Out-of-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.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
- ‡ You will pay the PCP's office visit copay when services are provided in their office.
- The representations of benefits in this document are subject to Indiana Department of Insurance (IN DOI) approval and are subject to change.

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.

Questions: (833) 578-4441 or visit us at www.anthem.com

Your summary of benefits

Anthem

Your Plan: Anthem Blue Access PPO Option 16 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.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date