

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 4

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	30% coinsurance after deductible is met
Mental Health & Substance Use Disorder Services	30% coinsurance after deductible is met
Specialist care	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	\$3,500 person / \$7,000 family	\$5,000 person / \$10,000 family
Overall Out-of-Pocket Limit	\$6,900 person / \$11,500 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 <i>virtual and office</i>	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Specialist Care <i>virtual and office</i>	30% coinsurance after deductible is met	40% coinsurance after deductible is met
<u>Other Practitioner Visits</u>		
Maternity Doctor services (prenatal/postnatal care and delivery)	30% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Retail Health Clinic for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Manipulation Therapy Coverage is limited to 24 visits per benefit period.	30% coinsurance after deductible is met	40% coinsurance after deductible is met
<u>Other Services in an Office</u> Allergy Testing Prescription Drugs Dispensed in the office Surgery	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	40% coinsurance after deductible is met
Preventive Care for Chronic Conditions per IRS guidelines	No charge	40% coinsurance after deductible is met
<u>Diagnostic Services</u> Lab Office Freestanding Lab/Reference Lab Outpatient Hospital	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met
X-Ray Office Outpatient Hospital	30% coinsurance after deductible is met 30% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met
Advanced Diagnostic Imaging for example: MRI, PET and CAT scans Office Freestanding Radiology Center	30% coinsurance after deductible is met 30% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after 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 deductible is met	40% coinsurance after deductible is met
<p><u>Emergency and Urgent Care</u></p> <p>Urgent Care</p> <p>Emergency Room Facility Services</p> <p>Emergency Room Doctor and Other Services</p> <p>Ambulance <i>Authorized Out-of-Network non-emergency ambulance services are limited to an Anthem maximum payment of \$50,000 per trip.</i></p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p>Outpatient Mental Health and Substance Use Disorder Services at a Facility</p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><u>Outpatient Surgery</u></p> <p>Facility Fees</p> <p>Hospital</p> <p>Ambulatory Surgical Center</p> <p>Physician and other services including surgeon fees</p> <p>Hospital</p> <p>Ambulatory Surgical Center</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u></p> <p>Facility Fees</p> <p>Human Organ and Tissue Transplants <i>Cornea transplants are treated the same as any other illness and subject to the medical benefits.</i></p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Physician and other services <i>including surgeon fees</i>	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Home Health Care <i>Coverage is limited to 100 visits per benefit period.</i>	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies.</i> <i>Coverage for physical and occupational therapies is unlimited visits per benefit period. Coverage for speech therapy is unlimited visits per benefit period.</i>		
Office	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Pulmonary rehabilitation <i>office and outpatient hospital</i> <i>Coverage is unlimited visits per benefit period.</i>	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Cardiac rehabilitation <i>office and outpatient hospital</i> <i>Coverage is unlimited visits per benefit period.</i>	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Dialysis/Hemodialysis <i>office and outpatient hospital</i>	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Chemo/Radiation Therapy <i>office and outpatient hospital</i>	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Skilled Nursing Care (facility) <i>Coverage for Skilled Nursing is limited to 60 days per benefit period</i>	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Inpatient Hospice	30% coinsurance after deductible is met	Covered as In-Network
Durable Medical Equipment	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Prosthetic Devices <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	30% coinsurance after deductible is met	40% coinsurance after 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.
- 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.

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

Your summary of benefits



Your Plan: Anthem Blue Access PPO HSA Option E6

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