

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access PPO – Plan 1-2

Your Network: Blue Access

Hoosier School Benefit Trust

Effective: 01/01/2021

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$1,500 person / \$3,000 family	\$3,000 person / \$6,000 family
Out-of-Pocket Limit	\$6,000 person / \$10,000 family	\$12,000 person / \$20,000 family
<p>The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.</p>		
Preventive Care / Screening / Immunization	No charge	40% coinsurance after deductible is met
<u>Doctor Home and Office Services</u>		
Primary Care Visit	\$40 copay per visit deductible does not apply	40% coinsurance after deductible is met
Specialist Care Visit	\$60 copay per visit deductible does not apply	40% coinsurance after deductible is met
Prenatal and Post-natal Care	30% coinsurance after deductible is met	40% coinsurance after deductible is met
<u>Other Practitioner Visits:</u>		
Retail Health Clinic	\$40 copay per visit deductible does not apply	40% coinsurance after deductible is met
Preferred On-line Visit <i>Includes Mental/Behavioral Health and Substance Abuse</i>	\$40 copay per visit deductible does not apply	40% coinsurance after deductible is met
Other Participating Provider On-line Visit <i>Includes Mental/Behavioral Health and Substance Abuse</i>	\$40 copay per visit deductible does not apply	40% coinsurance after deductible is met

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans, Inc. Independent licensee of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Questions: or visit us at www.anthem.com

Hoosier School Benefit Trust PPO Option 19 with Rx Option T1/Plan 1-2/Custom/01-01-2021

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Manipulation Therapy <i>Coverage is limited to 24 visits per benefit period.</i>	\$40 copay per visit deductible does not apply	40% coinsurance after deductible is met
<u>Other Services in an Office:</u> Allergy Testing Chemo/Radiation Therapy - PCP Chemo/Radiation Therapy - Specialist Dialysis/Hemodialysis Prescription Drugs - <i>Dispensed in the office</i>	30% coinsurance after deductible is met \$40 copay per visit deductible does not apply \$60 copay per visit deductible does not apply No charge 30% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met
<u>Diagnostic Services</u> Lab: Office Outpatient Hospital	No charge 30% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met
X-Ray: Office Outpatient Hospital	No charge 30% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met
Advanced Diagnostic Imaging: 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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<u>Emergency and Urgent Care</u> Urgent Care	\$100 copay per visit deductible does not apply	40% coinsurance after deductible is met
Emergency Room Facility Services <i>Copay waived if admitted.</i> Emergency Room Doctor and Other Services	\$250 copay per visit deductible does not apply No charge	Covered as In-Network Covered as In-Network
<u>Ambulance</u>	30% coinsurance after deductible is met	Covered as In-Network
<u>Outpatient Mental/Behavioral Health and Substance Abuse</u> Doctor Office Visit Facility visit: Facility Fees Doctor Services	\$40 copay per visit deductible does not apply 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
<u>Outpatient Surgery</u> Facility Fees: Hospital Freestanding Surgical Center Doctor and Other Services: Hospital Freestanding Surgical Center	30% coinsurance after deductible is met 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 40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><u>Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):</u></p> <p>Facility fees</p> <p>Human Organ and Tissue Transplants</p> <p>Doctor and other services</p>	<p>30% coinsurance after deductible is met</p> <p>No charge</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><u>Recovery & Rehabilitation</u></p> <p>Home Health Care <i>Coverage is limited to 100 visits per benefit period.</i></p>	<p>No cost share</p>	<p>40% coinsurance after deductible is met</p>
<p>Rehabilitation services:</p> <p>Office <i>Coverage for Physical Therapy is unlimited visits per benefit period. Coverage for Occupational Therapy is unlimited visits per benefit period Coverage for Speech Therapy is unlimited visits per benefit period.</i></p> <p>Outpatient Hospital <i>Coverage for Physical Therapy is unlimited visits per benefit period. Coverage for Occupational Therapy is unlimited visits per benefit period. Coverage for Speech Therapy is unlimited visits per benefit period.</i></p>	<p>\$60 copay per visit deductible does not apply</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>Cardiac rehabilitation</p> <p>Office <i>Coverage is unlimited per benefit period.</i></p> <p>Outpatient Hospital <i>Coverage is unlimited per benefit period.</i></p>	<p>\$60 copay per visit deductible does not apply</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>Skilled Nursing Care (facility) <i>Skilled Nursing is limited to 60 days per benefit period. Limit is combined In-Network and Non-Network. Benefit includes coverage for Outpatient Rehabilitation program.</i></p>	<p>30% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>
<p>Hospice</p>	<p>No charge</p>	<p>No charge</p>
<p>Durable Medical Equipment</p>	<p>30% 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 a Non-Network Provider
Prosthetic Devices	30% coinsurance after deductible is met	40% coinsurance after 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.
- All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum.
- 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 your plan includes out-of-network benefits, In-network and out-of-network deductibles, copayments, coinsurance and out-of-pocket maximum amounts are separate and do not accumulate toward each other.
- 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” which is generally coinsurance or coinsurance after your deductible is met.

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.

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.

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

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 .

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 :

Chinese(中文) : 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電。

Farsi (فارسی): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره تماس بگردید.

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 .

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 .

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero .

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、
にお電話ください。

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 문의하십시오.

Language Access Services:

Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'idiilkidgo ná bohónéedzǎ dóó bee ahóót'i' t'áá ni nizaad k'ehǫ́ bee nił hodoonih t'áadoo bǫ́ǫ́h ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih ninízingo kojí' hodíílnih .

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: .

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, ਤੇ ਕਾਲ ਕਰੋ।

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. .

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al .

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 .

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi .

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.