

# Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access PPO HSA – Plan 4

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
<b>Overall Deductible</b>	\$3,500 person / \$7,000 family	\$5,000 person / \$10,000 family
<b>Out-of-Pocket Limit</b>	\$6,900 person / \$11,500 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>		
<b>Preventive Care / Screening / Immunization</b>	No charge	40% coinsurance after deductible is met
<b><u>Doctor Home and Office Services</u></b>		
<b>Primary Care Visit</b>	30% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Specialist Care Visit</b>	30% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Prenatal and Post-natal Care</b>	30% coinsurance after deductible is met	40% coinsurance after deductible is met
<b><u>Other Practitioner Visits:</u></b>		
Retail Health Clinic	30% coinsurance after deductible is met	40% coinsurance after deductible is met
On-line Visit <i>Includes Mental/Behavioral Health and Substance Abuse</i>	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Manipulation Therapy <i>Coverage is limited to 24 visits per benefit period.</i>	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 a Non-Network Provider
<p><b><u>Other Services in an Office:</u></b></p> <p>Allergy Testing</p> <p>Chemo/Radiation Therapy</p> <p>Dialysis/Hemodialysis</p> <p>Prescription Drugs - <i>Dispensed in the office</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>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><b><u>Diagnostic Services</u></b></p> <p><b>Lab:</b></p> <p>Office</p> <p>Outpatient Hospital</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><b>X-Ray:</b></p> <p>Office</p> <p>Outpatient Hospital</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><b>Advanced Diagnostic Imaging:</b></p> <p>Office</p> <p>Outpatient Hospital</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><b><u>Emergency and Urgent Care</u></b></p> <p><b>Urgent Care</b></p>	<p>30% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>
<p><b>Emergency Room Facility Services</b></p>	<p>30% coinsurance after deductible is met</p>	<p>Covered as In-Network</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Emergency Room Doctor and Other Services</b>	30% coinsurance after deductible is met	Covered as In-Network
<b><u>Ambulance</u></b>	30% coinsurance after deductible is met	Covered as In-Network
<b><u>Outpatient Mental/Behavioral Health and Substance Abuse</u></b> <b>Doctor Office Visit</b>  <b>Facility visit:</b> Facility Fees  Doctor Services	30% coinsurance after deductible is met     30% coinsurance after deductible is met  30% coinsurance after deductible is met	Covered as In-Network   40% coinsurance after deductible is met  40% coinsurance after deductible is met  40% coinsurance after deductible is met
<b><u>Outpatient Surgery</u></b> <b>Facility Fees:</b> Hospital  Freestanding Surgical Center  <b>Doctor and Other Services:</b> 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
<b><u>Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):</u></b> <b>Facility fees</b>  <b>Human Organ and Tissue Transplants</b>	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
<b>Doctor and other services</b>	30% coinsurance after deductible is met	40% coinsurance after deductible is met
<b><u>Recovery &amp; Rehabilitation</u></b> <b>Home Health Care</b> <i>Coverage is limited to 100 visits per benefit period.</i>	30% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Rehabilitation services:</b>  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>  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>	30% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Cardiac rehabilitation</b>  Office <i>Coverage is unlimited visits per benefit period.</i>  Outpatient Hospital <i>Coverage is unlimited visits per benefit period.</i>	30% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Skilled Nursing Care (facility)</b> <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>	30% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Hospice</b>	30% coinsurance after deductible is met	Covered as In-Network
<b>Durable Medical Equipment</b>	30% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Prosthetic Devices</b>	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。

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**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 .

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

## Language Access Services:

**Navajo (Diné):** Dii naaltsoos biká'ígíí lahgo bina'ídiilkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj̄ bee nił hodoonih t'áadoo bąąh ilínígóó. Ata' halne'ígíí la' bich'į' hadeesdzih ninizingo koj̄' hodiilnih .

**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: .

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**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 .

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