

# Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access PPO

Your Network: Blue Access

Plan 3

Hoosier School Benefit Trust

Effective: 01/01/2024

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 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.

All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit.

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).*

<b>Primary Care (PCP) and Mental Health and Substance Use Disorder Services</b> <i>virtual and office</i>	\$40 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
<b>Specialist Care</b> <i>virtual and office</i>	\$60 copay per visit medical deductible does not apply	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
<p><b><u>Other Practitioner Visits</u></b></p> <p><b>Routine Maternity Care</b> (Prenatal and Postnatal)</p> <p><b>Retail Health Clinic</b> for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</p> <p><b>Manipulation Therapy</b> Coverage is limited to 24 visits per benefit period.</p>	<p>30% coinsurance after medical deductible is met</p> <p>\$40 copay per visit medical deductible does not apply</p> <p>\$40 copay per visit medical deductible does not apply</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>
<p><b><u>Other Services in an Office</u></b></p> <p><b>Allergy Testing</b> 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.</p> <p><b>Prescription Drugs</b> Dispensed in the office</p> <p><b>Surgery</b></p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p> <p>\$60 copay per visit medical deductible does not apply<sup>†</sup></p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>
<p><b>Preventive care / screenings / immunizations</b></p>	<p>No charge</p>	<p>50% coinsurance after medical deductible is met</p>
<p><b>Preventive Care for Chronic Conditions per IRS guidelines</b></p>	<p>No charge</p>	<p>50% coinsurance after medical deductible is met</p>
<p><b><u>Diagnostic Services</u></b></p> <p><b>Lab</b></p> <p>Office</p> <p>Freestanding Lab/Reference Lab</p> <p>Outpatient Hospital</p>	<p>No charge</p> <p>No charge</p> <p>30% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>X-Ray</b></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>No charge</p> <p>30% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>
<p><b>Advanced Diagnostic Imaging</b> <i>for example: MRI, PET and CAT scans</i></p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>
<p><b><u>Emergency and Urgent Care</u></b></p> <p><b>Urgent Care</b> <i>includes doctor services. Additional charges may apply depending on the care provided.</i></p> <p><b>Emergency Room Facility Services</b> <i>Your copay will be waived if admitted.</i></p> <p><b>Emergency Room Doctor and Other Services</b></p> <p><b>Ambulance</b> <i>Authorized Non-Network non-emergency ambulance services are limited to an Anthem maximum payment of \$50,000 per trip.</i></p>	<p>\$100 copay per visit medical deductible does not apply</p> <p>\$250 copay per visit medical deductible does not apply</p> <p>No charge</p> <p>30% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p><b>Outpatient Mental Health and Substance Use Disorder Services at a Facility</b></p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>

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

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
<b>Pulmonary rehabilitation</b> <i>Coverage is unlimited visits per benefit period.</i>  Office  Outpatient Hospital	\$60 copay per visit medical deductible does not apply  30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met  50% coinsurance after medical deductible is met
<b>Cardiac rehabilitation</b> <i>Coverage is unlimited visits per benefit period.</i>  Office  Outpatient Hospital	\$60 copay per visit medical deductible does not apply  30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met  50% coinsurance after medical deductible is met
<b>Dialysis/Hemodialysis</b>  Office  Outpatient Hospital	No charge  30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met  50% coinsurance after medical deductible is met
<b>Chemo/Radiation Therapy</b>  Office  Outpatient Hospital	\$60 copay per visit medical deductible does not apply <sup>‡</sup>  30% coinsurance after medical deductible is met	50% 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
<b>Skilled Nursing Care (facility)</b> <i>Coverage for Skilled Nursing is limited to 60 days per benefit period.</i>	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
<b>Inpatient Hospice</b>	No charge	No charge
<b>Durable Medical Equipment</b>	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
<b>Prosthetic Devices</b> <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	30% coinsurance after medical deductible is met	50% 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 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.
- ‡ 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.*

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

# Your summary of benefits




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.

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)	 HSBT CHAIRPERSON	Date	2023-September-07
Underwriting signature (if applicable)		Date	

## 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)

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## Language Access Services:

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