

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access PPO

Your Network: Blue Access

Southeastern IN School Ins 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 <i>The deductible for In-Network and Non-Network are added separately and do not apply towards each other.</i>	\$1,500 person / \$3,000 family	\$3,000 person / \$6,000 family
Out-of-Pocket Limit <i>The Out-of-Pocket limit for In-Network and Non-Network are added separately and do not apply towards each other.</i>	\$2,500 person / \$5,000 family	\$5,000 person / \$10,000 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	50% coinsurance after deductible is met
<u>Doctor Home and Office Services</u>		
Primary Care Visit <i>When Allergy injections are billed separately by network providers, the member is responsible for a \$5 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.</i>	\$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Specialist Care Visit <i>When Allergy injections are billed separately by network providers, the member is responsible for a \$5 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.</i>	\$50 copay per visit deductible does not apply	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prenatal and Post-natal Care	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<u>Other Practitioner Visits:</u> Retail Health Clinic Preferred On-line Visit <i>Includes Mental/Behavioral Health and Substance Abuse</i> Other Participating Provider On-line Visit <i>Includes Mental/Behavioral Health and Substance Abuse</i> Manipulation Therapy <i>Coverage is limited to 24 visits per benefit period.</i>	\$50 copay per visit deductible does not apply \$50 copay per visit deductible does not apply \$50 copay per visit deductible does not apply \$50 copay per visit deductible does not apply	50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% 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>	20% coinsurance after deductible is met \$50 copay per visit deductible does not apply \$50 copay per visit deductible does not apply No charge 20% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met
<u>Diagnostic Services</u> Lab: Office Freestanding Lab/Reference Lab	No charge No charge	50% coinsurance after deductible is met 50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
X-Ray: Office Outpatient Hospital	No charge 20% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met
Advanced Diagnostic Imaging: Office Freestanding Radiology Center Outpatient Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met
<u>Emergency and Urgent Care</u> Urgent Care <i>When Allergy injections are billed separately by network providers, the member is responsible for a \$5 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.</i>	\$75 copay per visit deductible does not apply	50% 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>	20% coinsurance after deductible is met	Covered as In-Network
<u>Outpatient Mental/Behavioral Health and Substance Abuse</u> Doctor Office Visit Facility visit:	\$50 copay per visit deductible does not apply	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Facility Fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<p><u>Outpatient Surgery</u></p> <p>Facility Fees:</p> <p>Hospital</p> <p>Freestanding Surgical Center</p> <p>Doctor and Other Services:</p> <p>Hospital</p> <p>Freestanding Surgical Center</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><u>Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):</u></p> <p>Facility fees</p> <p>Human Organ and Tissue Transplants <i>Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.</i></p> <p>Doctor and other services</p>	<p>20% coinsurance after deductible is met</p> <p>No charge</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% 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
<p><u>Recovery & Rehabilitation</u></p> <p>Home Health Care <i>Coverage is limited to 100 visits per benefit period.</i></p>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<p>Rehabilitation services:</p> <p>Office <i>Coverage for Speech Therapy is limited to 40 visits per benefit period.</i></p> <p>Outpatient Hospital <i>Coverage for Speech Therapy is limited to 40 visits per benefit period.</i></p>	<p>\$50 copay per visit deductible does not apply</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p>Cardiac rehabilitation</p> <p>Office <i>Coverage is limited to 36 visits per benefit period.</i></p> <p>Outpatient Hospital <i>Coverage is limited to 36 visits per benefit period.</i></p>	<p>\$50 copay per visit deductible does not apply</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p>Skilled Nursing Care (facility) <i>Skilled Nursing is limited to 90 days per benefit period. Limit is combined In-Network and Non-Network.</i></p>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<p>Hospice</p>	No charge	No charge
<p>Durable Medical Equipment</p>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<p>Prosthetic Devices</p>	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Notes:

- Dependent age: to end of the year 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.

Your Plan: Anthem Blue Access PPO Option 15 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

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)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (833) 578-4441.

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՝ (833) 578-4441:

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(833) 578-4441。

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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 (833) 578-4441.

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Language Access Services:

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(833) 578-4441로 문의하십시오.

Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'idiikidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj̄ bee nił hodoonih t'áadoo bááh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih ninízingo koj̄' hodiilnih (833) 578-4441.

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: (833) 578-4441.

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 ਦੁਬਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (833) 578-4441 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. (833) 578-4441.

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