# Your summary of benefits

Anthem® Blue Cross and Blue Shield

Hoosier School Benefit Trust — Effective 1/1/2026

Your Plan: Anthem Blue Access PPO HSA — Plan 5

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** | $5,700 person / $11,400 family | $10,000 person / $20,000 family |
| **Overall Out-of-Pocket Limit** | $6,900 person / $13,800 family | $12,900 person / $25,800 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.<br>All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit.<br>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). For members up to age 19, visits with In-Network Providers for primary care, and mental health and substance use disorder services are covered at no charge.* | | |
| **Primary Care (PCP) and Mental Health and Substance Use Disorder Services** *virtual and office* | 30% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Specialist Provider** *virtual and office* | 30% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Other Practitioner Visits** | | |
| **Maternity Doctor services** (prenatal/postpartum care and delivery) | 30% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **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 | 50% 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 |
|---|---|---|
| **Other Services in an Office** | | |
| **Allergy Testing** | 30% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Prescription Drugs** *Dispensed in the office* | 30% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Surgery** | 30% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Preventive care / screenings / immunizations** | No charge | 50% coinsurance after deductible is met |
| **Preventive Care for Chronic Conditions** *per IRS guidelines* | No charge | 50% coinsurance after deductible is met |
| **Diagnostic Services Lab** | | |
| Office | 30% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Freestanding Lab/Reference Lab | 30% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Outpatient Hospital | 30% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Diagnostic Services X-Ray** | | |
| Office | 30% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Outpatient Hospital | 30% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Diagnostic Services Advanced Diagnostic Imaging** *for example: MRI, PET and CAT scans* | | |
| Office | 30% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Freestanding Radiology Center | 30% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Outpatient Hospital | 30% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Emergency and Urgent Care** | | |
| **Urgent Care** | 30% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Emergency Room Facility Services** | 30% coinsurance after deductible is met | Covered as In-Network |
| **Emergency Room Doctor and Other Services** | 30% coinsurance after deductible is met | Covered as In-Network |
| **Ambulance** *Authorized Out-of-Network non-emergency ambulance services are limited to an Anthem maximum payment of $50,000 per trip. The $50,000 limit does not apply to air ambulance services.* | 30% coinsurance after deductible is met | Covered as In-Network |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|
| **Outpatient Mental Health and Substance Use Disorder Services at a Facility** | | |
| **Facility Fees** | 30% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Doctor Services** | 30% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Outpatient Surgery** | | |
| **Facility Fees** | | |
| Hospital | 30% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Ambulatory Surgical Center | 30% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Physician and other services** *including surgeon fees* | | |
| Hospital | 30% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Ambulatory Surgical Center | 30% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)** | | |
| **Facility Fees** | 30% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Human Organ and Tissue Transplants**<br>*Cornea transplants are treated as medical procedures, with benefits and cost sharing determined by the setting in which the services are received.* | 30% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Physician and other services** *including surgeon fees* | 30% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Home Health Care**<br>*Coverage is limited to 100 visits per benefit period.* | 30% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Therapy Services** | | |
| **Rehabilitation and Habilitation services** *including physical, occupational and speech therapies.*<br>*Coverage for physical and occupational therapies is unlimited visits per benefit period. Coverage for speech therapy is unlimited visits per benefit period.* | | |
| Office | 30% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Outpatient Hospital | 30% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Manipulation Therapy** *office and outpatient hospital*<br>*Coverage is limited to 24 visits per benefit period.* | 30% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Pulmonary rehabilitation** *office and outpatient hospital*<br>*Coverage is unlimited visits per benefit period.* | 30% 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 an Out-of-Network Provider |
|---|---|---|
| **Cardiac rehabilitation** *office and outpatient hospital*<br>*Coverage is unlimited visits per benefit period.* | 30% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Dialysis/Hemodialysis** *office and outpatient hospital* | 30% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Chemo/Radiation Therapy** *office and outpatient hospital* | 30% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Skilled Nursing Care (facility)**<br>*Coverage for Skilled Nursing is limited to 60 days per benefit period.* | 30% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Inpatient Hospice** | 30% coinsurance after deductible is met | Covered as In-Network |
| **Additional Services, Equipment and Devices**<br>**Durable Medical Equipment** | 30% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Prosthetic Devices** | 30% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Wigs**<br>*Coverage for wigs is limited to 1 item after cancer treatment per benefit period.* | 30% coinsurance after deductible is met | 50% coinsurance after deductible is met |

| Covered Prescription Drug Benefits | Cost if you use a Preferred Network Pharmacy | Cost if you use an Out-of-Network Pharmacy |
|---|---|---|
| **Pharmacy Deductible** | Combined with In-Network medical deductible | Combined with Out-of-Network medical deductible |
| **Pharmacy Out-of-Pocket Limit** | Combined with In-Network medical out-of-pocket limit | Combined with Out-of-Network medical out-of-pocket limit |
| **Prescription Drug Coverage**<br>**Network:** ***Base Network***<br>**Drug List:** ***National Direct Preferred*** *Drugs not included on the drug list will not be covered.* | | |
| **Day Supply Limits:**<br>**Retail Pharmacy** *30 day supply (cost shares noted below)*<br>**Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies noted below applies).*<br>**Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.*<br>**Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy. Drug cost share assistance programs may be available for certain specialty drugs.* | | |
| **Tier 1 - Typically Generic** | 30% coinsurance after deductible is met (retail and home delivery) | 50% coinsurance after deductible is met (retail) and Not covered (home delivery) |

| Covered Prescription Drug Benefits | Cost if you use a Preferred Network Pharmacy | Cost if you use an Out-of-Network Pharmacy |
|---|---|---|
| **Tier 2 - Typically Preferred Brand** | 30% coinsurance after deductible is met (retail and home delivery) | 50% coinsurance after deductible is met (retail) and Not covered (home delivery) |
| **Tier 3 - Typically Non-Preferred Brand** | 30% coinsurance after deductible is met (retail and home delivery) | 50% coinsurance after deductible is met (retail) and Not covered (home delivery) |
| **Tier 4 - Typically Specialty (brand and generic)** | 30% coinsurance after deductible is met (retail and home delivery) | 50% coinsurance after deductible is met (retail) and Not covered (home delivery) |

**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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