Your summary of benefits

Anthem

Anthem® Blue Cross and Blue Shield
Your Plan: Anthem Blue Access PPO HSA (with Copay)
Your Network: Blue Access

Southeastern IN School Ins Trust
Plan 1
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 *The deductible for In-Network and Non-Network are added separately and do not apply towards each other.*	$3,000 person / $6,000 family	$6,000 person / $12,000 family
Out-of-Pocket Limit *The Out-of-Pocket limit for In-Network and Non-Network are added separately and do not apply towards each other.*	$4,000 person / $8,000 family	$12,000 person / $24,000 family
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.		
Preventive Care / Screening / Immunization	No charge	30% coinsurance after deductible is met
Doctor Home and Office Services **Primary Care Visit** *When Allergy injections are billed separately by network providers, the member is responsible for $5 copay after deductible is met. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$50 copay per visit after deductible is met	30% coinsurance after deductible is met
Specialist Care Visit *When Allergy injections are billed separately by network providers, the member is responsible for $5 copay after deductible is met. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$50 copay per visit after deductible is met	30% 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	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	$50 copay per visit after deductible is met	30% coinsurance after deductible is met
Preferred On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	$50 copay per visit after deductible is met	30% coinsurance after deductible is met
Other Participating Provider On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	$50 copay per visit after deductible is met	30% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 24 visits per benefit period.*	$50 copay per visit after deductible is met	30% coinsurance after deductible is met
Other Services in an Office:		
Allergy Testing	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy - PCP	$50 copay per visit after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy - Specialist	$50 copay per visit after deductible is met	30% coinsurance after deductible is met
Dialysis/Hemodialysis	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Prescription Drugs - *Dispensed in the office*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Diagnostic Services **Lab:**		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Lab/Reference Lab	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
X-Ray:		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Advanced Diagnostic Imaging:		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Radiology Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care *When Allergy injections are billed separately by network providers, the member is responsible for $5 copay after deductible is met. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$75 copay per visit after deductible is met	30% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$250 copay per visit and 0% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	0% coinsurance after deductible is met	Covered as In-Network
Ambulance	0% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	$50 copay per visit after deductible is met	30% coinsurance after deductible is met
Facility visit:		
Facility Fees	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Doctor Services	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Surgical Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Surgical Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):		
Facility fees	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Human Organ and Tissue Transplants *Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor and other services	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 100 visits per benefit period.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Rehabilitation services:		
Office *Coverage for Speech Therapy is limited to 40 visits per benefit period.*	$50 copay per visit after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital *Coverage for Speech Therapy is limited to 40 visits per benefit period.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Cardiac rehabilitation Office *Coverage is limited to 36 visits per benefit period.* Outpatient Hospital *Coverage is limited to 36 visits per benefit period.*	 $50 copay per visit after deductible is met 0% coinsurance after deductible is met	 30% coinsurance after deductible is met 30% coinsurance after deductible is met
Skilled Nursing Care (facility) *Skilled Nursing is limited to 90 days per benefit period. Limit is combined In-Network and Non-Network.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Hospice	0% coinsurance after deductible is met	Covered as In-Network
Durable Medical Equipment	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Prosthetic Devices	0% coinsurance after deductible is met	30% 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 HSA (with Copay) Option E2 with Rx Option T14 (PrevRx)

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

Language Access Services:

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

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(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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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、(833) 578-4441 にお電話ください。

Language Access Services:

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Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'ídiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ąh ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínízingo kojį' hodíílnih (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.

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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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