# Your summary of benefits

Anthem

Anthem® Blue Cross and Blue Shield
Your Plan: Anthem Blue Access PPO HSA
Your Network: Blue Access

Effective: 1/1/2026
Southeastern IN School Ins Trust

| Visits with Virtual Care-Only Providers | Cost through our mobile app and website |
|---|---|
| **Primary Care, and medical services for urgent/acute care** | No charge after deductible is met |
| **Mental Health & Substance Use Disorder Services** | No charge after deductible is met |
| **Specialist care** | No charge 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** | $6,000 person / $12,000 family | $12,000 person / $24,000 family |
| **Overall Out-of-Pocket Limit** | $6,000 person / $12,000 family | $12,000 person / $24,000 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.<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).* | | |
| **Primary Care (PCP) and Mental Health and Substance Use Disorder Services** *virtual and office* | No charge after deductible is met | 30% coinsurance after deductible is met |
| **Specialist Provider** *virtual and office* | No charge after deductible is met | 30% coinsurance after deductible is met |
| **Other Practitioner Visits** | | |
| **Maternity Doctor services** (prenatal/postpartum care and delivery) | No charge after deductible is met | 30% coinsurance after deductible is met |
| **Retail Health Clinic** *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.* | No charge after deductible is met | 30% coinsurance after deductible is met |
| **Other Services in an Office** | | |
| **Allergy Testing** | No charge after deductible is met | 30% coinsurance after deductible is met |
| **Prescription Drugs** *Dispensed in the office* | No charge 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 an Out-of-Network Provider |
|---|---|---|
| **Surgery** | No charge after deductible is met | 30% coinsurance after deductible is met |
| **Preventive care / screenings / immunizations** | No charge | 30% coinsurance after deductible is met |
| **Preventive Care for Chronic Conditions** *per IRS guidelines* | No charge | Cost share is based on the setting services are received. |
| **Diagnostic Services Lab** | | |
| Office | No charge after deductible is met | 30% coinsurance after deductible is met |
| Freestanding Lab/Reference Lab | No charge after deductible is met | 30% coinsurance after deductible is met |
| Outpatient Hospital | No charge after deductible is met | 30% coinsurance after deductible is met |
| **Diagnostic Services X-Ray** | | |
| Office | No charge after deductible is met | 30% coinsurance after deductible is met |
| Outpatient Hospital | No charge after deductible is met | 30% coinsurance after deductible is met |
| **Diagnostic Services Advanced Diagnostic Imaging** *for example: MRI, PET and CAT scans* | | |
| Office | No charge after deductible is met | 30% coinsurance after deductible is met |
| Freestanding Radiology Center | No charge after deductible is met | 30% coinsurance after deductible is met |
| Outpatient Hospital | No charge after deductible is met | 30% coinsurance after deductible is met |
| **Emergency and Urgent Care** | | |
| **Urgent Care** | No charge after deductible is met | 30% coinsurance after deductible is met |
| **Emergency Room Facility Services** | No charge after deductible is met | Covered as In-Network |
| **Emergency Room Doctor and Other Services** | No charge after deductible is met | Covered as In-Network |
| **Ambulance** | No charge after deductible is met | Covered as In-Network |
| **Outpatient Mental Health and Substance Use Disorder Services at a Facility** | | |
| **Facility Fees** | No charge after deductible is met | 30% coinsurance after deductible is met |
| **Doctor Services** | No charge 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 an Out-of-Network Provider |
|---|---|---|
| **Outpatient Surgery** | | |
| **Facility Fees** | | |
| Hospital | No charge after deductible is met | 30% coinsurance after deductible is met |
| Ambulatory Surgical Center | No charge after deductible is met | 30% coinsurance after deductible is met |
| **Physician and other services** *including surgeon fees* | | |
| Hospital | No charge after deductible is met | 30% coinsurance after deductible is met |
| Ambulatory Surgical Center | No charge after deductible is met | 30% coinsurance after deductible is met |
| **Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)** | | |
| **Facility Fees** | No charge after deductible is met | 30% 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.* | No charge after deductible is met | 30% coinsurance after deductible is met |
| **Physician and other services** *including surgeon fees* | No charge after deductible is met | 30% coinsurance after deductible is met |
| **Home Health Care**<br>*Coverage is limited to 100 visits per benefit period.* | No charge after deductible is met | 30% coinsurance after deductible is met |
| **Therapy Services** | | |
| **Rehabilitation and Habilitation services** *including physical, occupational and speech therapies.*<br>*Coverage for occupational therapy is limited to 90 visits per benefit period, physical therapy is limited to 90 visits per benefit period and speech therapy is limited to 40 visits per benefit period* | | |
| Office | No charge after deductible is met | 30% coinsurance after deductible is met |
| Outpatient Hospital | No charge after deductible is met | 30% coinsurance after deductible is met |
| **Manipulation Therapy** *office and outpatient hospital*<br>*Coverage is limited to 24 visits per benefit period.* | No charge after deductible is met | 30% coinsurance after deductible is met |
| **Pulmonary rehabilitation** *office and outpatient hospital*<br>*Coverage is limited to 20 visits per benefit period.* | No charge after deductible is met | 30% coinsurance after deductible is met |
| **Cardiac rehabilitation** *office and outpatient hospital*<br>*Coverage is limited to 36 visits per benefit period.* | No charge after deductible is met | 30% coinsurance after deductible is met |
| **Dialysis/Hemodialysis** *office and outpatient hospital* | No charge after deductible is met | 30% coinsurance after deductible is met |
| **Chemo/Radiation Therapy** *office and outpatient hospital* | No charge 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 an Out-of-Network Provider |
|---|---|---|
| **Skilled Nursing Care (facility)**<br>*Coverage for Skilled Nursing is limited to 90 days per benefit period* | No charge after deductible is met | 30% coinsurance after deductible is met |
| **Inpatient Hospice** | No charge after deductible is met | Covered as In-Network |
| **Additional Services, Equipment and Devices** | | |
| **Durable Medical Equipment** | No charge after deductible is met | 30% coinsurance after deductible is met |
| **Prosthetic Devices** | No charge after deductible is met | 30% coinsurance after deductible is met |
| **Wigs**<br>*Coverage for wigs is limited to 1 item after cancer treatment per benefit period.* | No charge after deductible is met | 30% coinsurance after 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 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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