

# Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: Indiana State University: PPO

Your Network: BlueCard PPO

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	\$25 copay per visit deductible does not apply
Mental Health & Substance Use Disorder Services	\$25 copay per visit deductible does not apply
Specialist care	\$40 copay per visit deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<b>Overall Deductible</b>	\$500 person / \$1,500 family	\$500 person / \$1,500 family
<b>Overall Out-of-Pocket Limit</b>	\$3,500 person / \$7,000 family	\$9,000 person / \$18,000 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 deductibles, copayments and coinsurance apply to the out-of-pocket limit.

The In-Network and Out-of-Network deductibles are combined and accumulate toward each other. The In-Network and Out-of-Network out-of-pocket limit amounts 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>	\$25 copay per visit deductible does not apply	50% coinsurance after deductible is met
<b>Specialist Provider</b> <i>virtual and office</i>	\$40 copay per visit deductible does not apply	50% coinsurance after deductible is met
<b>Other Practitioner Visits</b>		
<b>Maternity Doctor services</b> (prenatal/postpartum care and delivery) The first visit with In-Network provider to establish pregnancy diagnosis is \$25 copay deductible does not apply	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Retail Health Clinic</b> <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i>	\$25 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 an Out-of-Network Provider
<p><b><u>Other Services in an Office</u></b></p> <p><b>Allergy Testing</b></p> <p><b>Prescription Drugs</b> <i>Dispensed in the office</i></p> <p><b>Surgery</b></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 deductible does not apply</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><b>Preventive care / screenings / immunizations</b></p>	<p>No charge</p>	<p>50% coinsurance after deductible is met</p>
<p><b><u>Diagnostic Services Lab</u></b></p> <p>Office</p> <p>Freestanding Lab/Reference Lab</p> <p>Outpatient Hospital</p>	<p>\$25 copay per visit deductible does not apply</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><b><u>Diagnostic Services X-Ray</u></b></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$25 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><b><u>Diagnostic Services Advanced Diagnostic Imaging</u></b> <i>for example: MRI, PET and CAT scans</i></p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</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><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></p>	<p>\$50 copay per visit deductible does not apply</p> <p>\$200 copay per visit deductible does not apply</p> <p>No charge</p> <p>20% coinsurance after deductible is met</p>	<p>\$50 copay per visit deductible does not apply</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>

Revised 02/17/2026

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<p><b><u>Outpatient Mental Health and Substance Use Disorder Services at a Facility</u></b></p> <p><b>Facility Fees</b></p> <p><b>Doctor Services</b></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><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</b> <i>including surgeon fees</i></p> <p>Hospital</p> <p>Ambulatory Surgical Center</p>	<p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after 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 as medical procedures, with benefits and cost sharing determined by the setting in which the services are received.</i></p> <p><b>Physician and other services</b> <i>including surgeon fees</i></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>\$200 copay per admission and 50% coinsurance after deductible is met</p> <p>Not covered</p> <p>50% coinsurance after deductible is met</p>
<p><b><u>Home Health Care</u></b> <i>Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p>
<p><b><u>Therapy Services</u></b></p> <p><b>Rehabilitation and Habilitation services</b> <i>including physical, occupational and speech therapies.</i> <i>Coverage for physical, occupational, speech and pulmonary therapies is limited to 60 visits combined per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p> <p><b>Manipulation Therapy</b> <i>Coverage is limited to 60 visits per benefit period.</i></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>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Office	\$25 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Pulmonary rehabilitation</b> office and outpatient hospital <i>Coverage is limited to 60 visits per benefit period combined with physical, occupational and speech therapies.</i>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Cardiac rehabilitation</b> office and outpatient hospital <i>Coverage is limited to 36 days per benefit period.</i>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Dialysis/Hemodialysis</b> office and outpatient hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Chemo/Radiation Therapy</b> office and outpatient hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Skilled Nursing Care (facility)</b>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Inpatient Hospice</b> <i>Coverage is limited to life expectancy up to 12 months.</i>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b><u>Additional Services, Equipment and Devices</u></b>		
<b>Durable Medical Equipment</b>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Prosthetic Devices</b>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Wigs</b> <i>Coverage for wigs is limited to 1 unit per benefit period subject to medical necessity.</i>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Hearing Aids</b> <i>Coverage is limited to 2 items with \$500 maximum every 24 months.</i>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
<b>Pharmacy Deductible</b>	Combined with Medical	Not covered
<b>Pharmacy Out-of-Pocket Limit</b>	Combined with Medical	Not covered
<b>Prescription Drug Coverage</b> <b>Network: Caremark</b> <b>Drug List: National Formulary</b>		
<b>Day Supply Limits: 90 day supply if allowed by law</b> <b>GLP-1's for Wt Loss are not covered.</b>		

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Tier 1 - Typically Generic	20% coinsurance after deductible is met	Not covered
Tier 2 - Typically Preferred Brand	20% coinsurance after deductible is met	Not covered
Tier 3 - Typically Non-Preferred Brand	20% coinsurance after deductible is met	Not covered
Tier 4 - Typically Specialty (brand and generic)	20% coinsurance after deductible is met	Not covered

**Notes:**

- Dependent Age Limit: to the end of the year 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.

*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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