Your summary of benefits

Anthem® Blue Cross and Blue Shield

Effective 1/1/2022

Seymour Community School Corp

Your Plan: Anthem Blue Access PPO HSA

Your Network: Blue Access

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$2,000 person / $4,000 family	$4,000 person / $8,000 family
Out-of-Pocket Limit	$4,000 person / $6,850 family	$8,000 person / $16,000 family
The family deductible and out-of-pocket maximum are non-embedded, meaning the cost shares of all family members apply to one shared family deductible and one shared family out-of-pocket maximum. The per person deductible and per person out-of-pocket maximum only apply to individuals enrolled under single coverage. Your copays, coinsurance and deductible count toward your out of pocket amount(s). In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other.		
Preventive Care / Screening / Immunization	No charge	40% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	40% coinsurance after deductible is met
Virtual Care (Telemedicine / Telehealth Visits)		
Virtual Visits - Online visits with Doctors who also provide services in person		
Primary Care (PCP)	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Mental Health and Substance Abuse care	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Specialist	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Medical Chats and Virtual Visits for Primary Care *from our Online Provider K Health, its affiliated Provider groups, via our mobile app, website or Anthem-enabled device*	0% coinsurance after deductible is met	
Virtual Visits from Online Provider LiveHealth Online *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*		
Primary Care (PCP) and Mental Health and Substance Abuse	20% coinsurance after deductible is met	
Specialist Care	20% coinsurance after deductible is met	
Visits in an Office		
Primary Care (PCP)	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Specialist Care	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Retail Health Clinic	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Manipulation Therapy *Coverage is unlimited visits per benefit period.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Other Services in an Office		
Allergy Testing	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Chemo/Radiation Therapy	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Dialysis/Hemodialysis	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Surgery	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Diagnostic Services **Lab**		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Lab/Reference Lab	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
X-Ray		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Emergency Room Facility Services	20% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	Covered as In-Network
Ambulance	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse		
Doctor Office Visit	20% coinsurance after deductible is met	40% 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 Visit		
Facility Fees	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor and Other Services		
Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	20% coinsurance after deductible is met	40% 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.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is unlimited visits per benefit period*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Rehabilitation services *Coverage for rehabilitative and habilitative physical therapy is unlimited visits per benefit period. Occupational therapy is unlimited visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is unlimited visits per benefit period.*		
Office	20% coinsurance after deductible is met	40% 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	40% coinsurance after deductible is met
Cardiac rehabilitation *Coverage is unlimited visits per benefit period.*		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Pulmonary rehabilitation *Coverage is unlimited visits per benefit period.*		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage for Skilled Nursing is unlimited days per benefit period. Limit is combined In-Network and Non-Network*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Inpatient Hospice	20% coinsurance after deductible is met	Covered as In-Network
Durable Medical Equipment	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with Non-Network medical deductible
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Prescription Drug Coverage *Cost shares for drugs included on the **National** drug list appear below. Your plan uses the Base Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies.*		

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use a Non-Network Pharmacy
Home Delivery Pharmacy *Maintenance medication are available through IngenioRx 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.*		
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	20% coinsurance after deductible is met (retail and home delivery)	40% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	20% coinsurance after deductible is met (retail and home delivery)	40% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	20% coinsurance after deductible is met (retail and home delivery)	40% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) *Per 30 day supply (specialty pharmacy).*	20% coinsurance after deductible is met (retail and home delivery)	40% coinsurance after deductible is met (retail) and Not covered (home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.		
<u>Children's Vision (up to age 19)</u> **Child Vision Deductible**	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
<u>Adult Vision (age 19 and older)</u> **Adult Vision Deductible**	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	No charge	Reimbursed Up to $42

Notes:

- Dependent age: to end of the month 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.
- 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 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.

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.