

# Your summary of benefits



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

Scott County School District 2

Effective 01/01/2021

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b> <i>The deductible for In-Network and Non-Network are added separately and do not apply towards each other.</i>	\$4,000 person / \$8,000 family	\$8,000 person / \$16,000 family
<b>Out-of-Pocket Limit</b> <i>The Out-of-Pocket limit for In-Network and Non-Network are added separately and do not apply towards each other.</i>	\$5,000 person / \$10,000 family	\$16,000 person / \$32,000 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.		
<b>Preventive Care / Screening / Immunization</b>	No charge	30% coinsurance after deductible is met
<b><u>Doctor Home and Office Services</u></b>		
<b>Primary Care Visit</b> <i>When Allergy injections are billed separately by network providers, the member is responsible for \$10 copay after deductible is met. When billed as part of an office visit, there is no additional cost to the member for the injection.</i>	\$30 copay per visit after deductible is met	30% coinsurance after deductible is met
<b>Specialist Care Visit</b> <i>When Allergy injections are billed separately by network providers, the member is responsible for \$10 copay after deductible is met. When billed as part of an office visit, there is no additional cost to the member for the injection.</i>	\$50 copay per visit after deductible is met	30% coinsurance after dedu ..... ..... .....ctible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Prenatal and Post-natal Care</b>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b><u>Other Practitioner Visits:</u></b> Retail Health Clinic  Preferred On-line Visit <i>Includes Mental/Behavioral Health and Substance Abuse</i>  Other Participating Provider On-line Visit <i>Includes Mental/Behavioral Health and Substance Abuse</i>  Manipulation Therapy <i>Coverage is limited to 12 visits per benefit period.</i>	\$30 copay per visit after deductible is met  \$10 copay per visit after deductible is met  \$30 copay per visit after deductible is met  \$50 copay per visit after deductible is met	30% coinsurance after deductible is met  30% coinsurance after deductible is met  30% coinsurance after deductible is met  30% coinsurance after deductible is met
<b><u>Other Services in an Office:</u></b>  Allergy Testing  Chemo/Radiation Therapy - PCP  Chemo/Radiation Therapy - Specialist  Dialysis/Hemodialysis  Prescription Drugs - <i>Dispensed in the office</i>	0% coinsurance after deductible is met  \$30 copay per visit after deductible is met  \$50 copay per visit after deductible is met  0% coinsurance after deductible is met  0% coinsurance after deductible is met	30% coinsurance after deductible is met  30% coinsurance after deductible is met  30% coinsurance after deductible is met  30% coinsurance after deductible is met  30% coinsurance after deductible is met
<b><u>Diagnostic Services</u></b> <b>Lab:</b> Office  Freestanding Lab/Reference Lab  Outpatient Hospital	0% coinsurance after deductible is met  0% coinsurance after deductible is met  0% coinsurance after deductible is met	30% coinsurance after deductible is met  30% 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
<b>X-Ray:</b> Office Outpatient Hospital	0% coinsurance after deductible is met 0% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met
<b>Advanced Diagnostic Imaging:</b> Office Freestanding Radiology Center Outpatient Hospital	0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met
<u><b>Emergency and Urgent Care</b></u> <b>Urgent Care</b> <i>When Allergy injections are billed separately by network providers, the member is responsible for \$10 copay after deductible is met. When billed as part of an office visit, there is no additional cost to the member for the injection.</i>	\$75 copay per visit after deductible is met	30% coinsurance after deductible is met
<b>Emergency Room Facility Services</b> <i>Copay waived if admitted.</i> <b>Emergency Room Doctor and Other Services</b>	\$250 copay per visit and 0% coinsurance after deductible is met 0% coinsurance after deductible is met	Covered as In-Network Covered as In-Network
<u><b>Ambulance</b></u>	0% coinsurance after deductible is met	Covered as In-Network
<u><b>Outpatient Mental/Behavioral Health and Substance Abuse</b></u> <b>Doctor Office Visit</b> <b>Facility visit:</b> Facility Fees	\$30 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



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
<p><b><u>Outpatient Surgery</u></b></p> <p><b>Facility Fees:</b></p> <p>Hospital</p> <p>Freestanding Surgical Center</p> <p><b>Doctor and Other Services:</b></p> <p>Hospital</p> <p>Freestanding Surgical Center</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><b><u>Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):</u></b></p> <p><b>Facility fees</b></p> <p><b>Human Organ and Tissue Transplants</b> <i>Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.</i></p> <p><b>Doctor and other services</b></p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b><u>Recovery &amp; Rehabilitation</u></b></p> <p><b>Home Health Care</b>  <i>Coverage is limited to 120 visits per benefit period. Limits are combined for all home health services.</i></p>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<p><b>Rehabilitation services:</b></p> <p>Office  <i>Coverage for Speech Therapy is limited to 20 visits per benefit period.</i></p> <p>Outpatient Hospital  <i>Coverage for Speech Therapy is limited to 20 visits per benefit period.</i></p>	<p>\$50 copay per visit after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><b>Cardiac rehabilitation</b></p> <p>Office  <i>Coverage is limited to 36 visits per benefit period.</i></p> <p>Outpatient Hospital  <i>Coverage is limited to 36 visits per benefit period.</i></p>	<p>\$50 copay per visit after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><b>Skilled Nursing Care (facility)</b>  <i>Coverage for Skilled Nursing, Outpatient Rehabilitation and Inpatient Rehabilitation facility settings is limited to 150 days combined per benefit period.</i></p>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<p><b>Hospice</b></p>	0% coinsurance after deductible is met	Covered as In-Network
<p><b>Durable Medical Equipment</b></p>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<p><b>Prosthetic Devices</b></p>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Covered Prescription Drug Benefits	Cost if you use a Preferred Network Provider	Cost if you use a Non-Network Provider
<p><b>Pharmacy Deductible</b></p>	Combined with In-Network medical deductible	Combined with Non-Network medical deductible

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Provider	Cost if you use a Non-Network Provider
<b>Pharmacy Out of Pocket</b>	Combined with In-Network medical	Combined with Non-Network medical
<b>Prescription Drug Coverage</b> <i>National w/R90 with Optional Home Delivery</i> <i>National Drug List</i> <i>This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs.</i>		
<b>Tier 1 - Typically Generic</b> <i>30 day supply (retail pharmacy). 90 day supply (home delivery).</i>	\$10 copay per prescription after deductible is met (retail) and \$20 copay per prescription after deductible is met (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
<b>Tier 2 – Typically Preferred Brand</b> <i>30 day supply (retail pharmacy). 90 day supply (home delivery).</i>	\$30 copay per prescription after deductible is met (retail) and \$90 copay per prescription after deductible is met (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
<b>Tier 3 - Typically Non-Preferred Brand</b> <i>30 day supply (retail pharmacy). 90 day supply (home delivery).</i>	\$60 copay per prescription after deductible is met (retail) and \$180 copay per prescription after deductible is met (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
<b>Tier 4 - Typically Specialty (brand and generic)</b> <i>30 day supply (retail pharmacy). 30 day supply (home delivery).</i>	25% coinsurance up to \$250 per prescription after deductible is met (retail and home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)



**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.
- 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.*