Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Plan: School District of Altoona: Anthem Blue Preferred Plus POS $4000

Your Network: Blue Preferred

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$4,000 person / $8,000 family	$8,000 person / $16,000 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. All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket limit(s) (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services). In-Network and Non-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).*		
Medical Chats and Virtual Visits for Primary Care *from our Online Provider K Health, through its affiliated Provider groups are covered at $0 copay per visit medical deductible does not apply.*		
Virtual Visits from online provider LiveHealth Online *for urgent/acute medical and mental health and substance abuse care via www.livehealthonline.com are covered at $0 copay per visit medical deductible does not apply; and $50 copay per visit medical deductible does not apply for covered Specialist Care.*		
Primary Care (PCP) and Mental Health and Substance Abuse Care *virtual and office*	$25 copay per visit medical deductible does not apply	20% coinsurance after medical deductible is met
Specialist Care *virtual and office*	$50 copay per visit medical deductible does not apply	20% coinsurance after medical deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$25 copay per visit medical deductible does not apply	20% coinsurance after medical deductible is met
Manipulation Therapy	$25 copay per visit medical deductible does not apply	20% coinsurance after medical deductible is met
Other Services in an Office		
Allergy Testing	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Prescription Drugs *Dispensed in the office*	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Surgery	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Preventive care / screenings / immunizations	No charge	20% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	20% coinsurance after medical deductible is met
Diagnostic Services **Lab**		
Office	No charge	20% coinsurance after medical deductible is met
Freestanding Lab/Reference Lab	No charge	20% coinsurance after medical deductible is met
Outpatient Hospital	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
X-Ray		
Office	No charge	20% coinsurance after medical deductible is met
Freestanding Radiology Center	No charge	20% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Freestanding Radiology Center	$250 copay per visit medical deductible does not apply	20% coinsurance after medical deductible is met
Outpatient Hospital	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	$100 copay per visit medical deductible does not apply	20% coinsurance after medical deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$250 copay per visit medical deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	0% coinsurance medical deductible does not apply	Covered as In-Network
Ambulance	0% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse Care at a Facility		
Facility Fees	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Doctor Services	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Ambulatory Surgical Center	$250 copay per visit medical deductible does not apply	20% coinsurance after medical deductible is met
Doctor and Other Services		
Hospital	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Ambulatory Surgical Center	No charge	20% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Human Organ and Tissue Transplants *Cornea transplants are treated the same as any other illness and subject to the medical benefits.*	No charge	50% coinsurance after medical deductible is met
Physician and other services *including surgeon fees*	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Home Health Care *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for physical and occupational therapies is limited to 40 visits combined per benefit period. Coverage for speech therapy is limited to 20 visits per benefit period.*		
Office	$50 copay per visit and 0% coinsurance medical deductible does not apply	20% coinsurance after medical deductible is met
Outpatient Hospital	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Pulmonary rehabilitation *Coverage is limited to 20 visits per benefit period.*		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Office	$50 copay per visit and 0% coinsurance medical deductible does not apply	20% coinsurance after medical deductible is met
Outpatient Hospital	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Cardiac rehabilitation *Coverage is limited to 36 visits per benefit period.*		
Office	$50 copay per visit and 0% coinsurance medical deductible does not apply	20% coinsurance after medical deductible is met
Outpatient Hospital	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Dialysis/Hemodialysis		
Office	No charge	20% coinsurance after medical deductible is met
Outpatient Hospital	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Chemo/Radiation Therapy		
Office	$50 copay per visit medical deductible does not apply‡	20% coinsurance after medical deductible is met
Outpatient Hospital	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Coverage is limited to 30 days per admission.*	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Inpatient Hospice	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Durable Medical Equipment	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Hearing Aids *Coverage is limited to 1 item per ear every 3 years for members under 18 years of age.*	0% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable
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 **Network:** ***Base Network*** **Drug List:** ***Essential*** *Drugs not included on the Essential drug list will not be covered.*		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail (IngenioRx will become CarelonRx on January 1, 2023). You will need to call us on the number on your ID card to sign up when you first use the service.* **Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.*		
Preventive Drugs *No deductible, copayment or coinsurance for In-Network drugs included on the PreventiveRx Plus drug list, a designated list of drugs to treat health conditions, such as: diabetes, asthma, depression, heart health, high blood pressure, high cholesterol, and osteoporosis.*		
Tier 1 - Typically Generic	$10 copay per prescription (retail) and $20 copay per prescription (home delivery)	50% coinsurance (retail) and Not covered (home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Tier 2 – Typically Preferred Brand	$40 copay per prescription (retail) and $80 copay per prescription (home delivery)	50% coinsurance (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	$80 copay per prescription (retail) and $160 copay per prescription (home delivery)	50% coinsurance (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	20% coinsurance up to $200 per prescription (retail and home delivery)	50% coinsurance (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. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out of pocket limit.		
Children's Vision exam (up to age 19) *Limited to 1 exam per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Adult Vision exam (age 19 and older) *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, Specialist or Urgent Care 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.
- ‡ Your cost share will be reduced when services are provided in a PCP's office.

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 Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.

Anthem

Your Plan: School District of Altoona: Anthem Blue Preferred Plus POS $4000

Your Network: Blue Preferred

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

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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) 578-4439

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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) 578-4439 .

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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) 578-4439.

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Language Access Services:

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