

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: TECHNOLOGY PARTNERS INC: Anthem Blue Access Choice PPO HSA 3400

Your Network: Blue Access Choice

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge deductible does not apply
Mental Health & Substance Use Disorder Services	No charge deductible does not apply
Specialist care	10% 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
Overall Deductible	\$3,400 person / \$6,800 family	\$6,000 person / \$12,000 family
Overall Out-of-Pocket Limit	\$5,500 person / \$11,000 family	\$11,000 person / \$22,000 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 to the out-of-pocket limit (excluding Out-of-Network Human Organ and Tissue Transplant (HOTT), Cellular and Gene Therapy services). 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) <i>You are encouraged to select a Primary Care Physician (PCP).</i>		
Primary Care (PCP) and Mental Health and Substance Use Disorder Services <i>virtual and office</i>	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Specialist Provider <i>virtual and office</i>	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Other Practitioner Visits		
Maternity Doctor services (prenatal/postpartum care and delivery)	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i>	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Chiropractic Services <i>Coverage is limited to 26 visits per benefit period.</i>	50% coinsurance after deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<u>Other Services in an Office</u>		
Allergy Testing	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Prescription Drugs <i>Dispensed in the office</i>	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Surgery	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	40% coinsurance after deductible is met
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	Cost share is based on the setting services are received.
<u>Diagnostic Services Lab</u>		
Office	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Reference Lab	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	40% coinsurance after deductible is met
<u>Diagnostic Services X-Ray</u>		
Office	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	40% coinsurance after deductible is met
<u>Diagnostic Services Advanced Diagnostic Imaging</u> <i>for example: MRI, PET and CAT scans</i>		
Office	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Radiology Center	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	40% coinsurance after deductible is met
<u>Emergency and Urgent Care</u>		
Urgent Care <i>includes doctor services. Additional charges may apply depending on the care provided.</i>	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Emergency Room Facility Services	10% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	10% coinsurance after deductible is met	Covered as In-Network
Ambulance	10% coinsurance after deductible is met	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<i>Authorized Out-of-Network non-emergency ambulance services are limited to an Anthem maximum payment of \$50,000 per trip. The \$50,000 limit does not apply to air ambulance services.</i>		
<u>Outpatient Mental Health and Substance Use Disorder Services at a Facility</u> Facility Fees Doctor Services	10% coinsurance after deductible is met 10% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met
<u>Outpatient Surgery</u> Facility Fees Hospital Ambulatory Surgical Center Physician and other services <i>including surgeon fees</i> Hospital Ambulatory Surgical Center	10% coinsurance after deductible is met 10% coinsurance after deductible is met 10% coinsurance after deductible is met 10% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met
<u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u> Facility Fees Human Organ and Tissue Transplants <i>Cornea transplants are treated as medical procedures, with benefits and cost sharing determined by the setting in which the services are received.</i> Physician and other services <i>including surgeon fees</i>	10% coinsurance after deductible is met 10% coinsurance after deductible is met 10% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met
<u>Home Health Care</u> <i>Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.</i>	10% coinsurance after deductible is met	40% coinsurance after deductible is met
<u>Therapy Services</u> Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies.</i> <i>Coverage for physical and occupational therapies is limited to 40 visits combined per benefit period. Limit includes manipulative treatment when performed by someone other than a Chiropractor. Speech therapy has no visit limit. Benefit limit does not apply when performed as part of Early Intervention.</i> Office	10% 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 an Out-of-Network Provider
Outpatient Hospital	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Pulmonary rehabilitation <i>office and outpatient hospital</i>	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Cardiac rehabilitation <i>office and outpatient hospital</i> <i>Coverage is limited to 36 visits per benefit period.</i>	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Dialysis/Hemodialysis <i>office and outpatient hospital</i>	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Chemo/Radiation Therapy <i>office and outpatient hospital</i>	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Skilled Nursing Care (facility) <i>Coverage for Skilled Nursing, Outpatient Rehabilitation and Inpatient Rehabilitation facility settings is limited to 150 days combined per benefit period.</i>	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Inpatient Hospice	10% coinsurance after deductible is met	40% coinsurance after deductible is met
<u>Additional Services, Equipment and Devices</u>		
Durable Medical Equipment	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Prosthetic Devices	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Wigs <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	10% coinsurance after deductible is met	40% coinsurance after deductible is met
Hearing Aids <i>Coverage for hearing aids is limited to children 1 through 17 years of age, with one hearing aid per ear every 36 months. Newborn hearing aids no limit.</i>	10% coinsurance after deductible is met	40% 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
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with Out-of-Network medical deductible
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Out-of-Network medical out-of-pocket limit
Prescription Drug Coverage Network: <i>Base Network</i> Drug List: <i>Essential</i> Drugs not included on the <i>Essential</i> drug list will not be covered.		

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
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 our 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. 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.		
Tier 1 - Typically Generic	\$10 copay per prescription after deductible is met (retail) and \$25 copay per prescription after deductible is met (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 - Typically Preferred Brand	\$45 copay per prescription after deductible is met (retail) and \$113 copay per prescription after deductible is met (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	\$70 copay per prescription after deductible is met (retail) and \$175 copay per prescription after deductible is met (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	25% coinsurance up to \$350 per prescription after deductible is met (retail and home delivery)	50% 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 an Out-of-Network Provider
<i>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.</i>		
Children's Vision exam (up to age 19) <i>Limited to 1 exam per benefit period.</i>	No charge	\$0 copayment up to plan's Maximum Allowed Amount

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Adult Vision exam (age 19 and older) <i>Limited to 1 exam per benefit period.</i>	No charge	Reimbursed Up to \$42

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.
- Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, 3D mammography, breast ultrasounds and MRIs are covered in full after deductible as required by state mandate.
- 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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