School Administrative Unit #39 - All Other Employees

HealthTrust		Access Blue (AB5)	Access Blue Site of Service (ABSOS20/40/1KDED)	Lumenos 2500 (LUMENOS2500)	
		RX Benefit: RX10/20/45/3K	RX Benefit: RX10/20/45/5K	RX Benefit: Lumenos RX	
		Network Benefits (1)	Network Benefits (1)	Network Benefits	Out-of-Network Benefits (2)
Cost Sharing	Visit Copayment	$5 per visit	$20 per visit	N/A	
	Specialty Visit Copayment	$5 per visit	$40 per visit	N/A	
	Walk-In Center or Retail Clinic Copayment	$5 per visit	$20 per visit	N/A	
	Urgent Care Facility Copayment	$25 per visit	$50 per visit	N/A	
	Emergency Room Copayment	$25 per visit	$100 per visit	N/A	
	Standard Deductible	N/A	$1,000 per Member per year; $3,000 per family per year	$2,500 per Member, per year; $5,000 per 2-person or family per year (3)	
	Standard Coinsurance	N/A	N/A	N/A	30%
	Coinsurance Maximum	N/A	N/A	N/A	$2,500 per Member, per year; $5,000 per 2-person or family per year (3)
	Durable Medical Equipment	You pay 20%	You pay 20% after separate $100 per Member, per year deductible	Standard Deductible	Standard Deductible and Coinsurance
	Out-of-Pocket Limit	$3,000 per Member, per year; $6,000 per family, per year (4)	$5,000 per Member, per year; $10,000 per family, per year (4)	$2,500 per Member, per year; $5,000 per 2-person or family per year (4)	$5,000 per Member, per year; $10,000 per family, per year (4) (3)
Inpatient	Inpatient Services; Medical, Surgical and Maternity Admissions	You pay $0	Standard Deductible	Standard Deductible	Standard Deductible and Coinsurance plus any balances
Preventive Care	Immunizations, cancer screenings: mammograms, pap smears, routine colonoscopy; routine physical exams, nutrition counseling, diabetes management program, routine hearing exams (one exam each year)	You pay $0	You pay $0	You pay $0	Standard Deductible and Coinsurance plus any balances
	Routine Eye Exams (one exam per year 18 years and younger; once every two years thereafter)	You pay $0	You pay $0	You pay $0	Standard Deductible and Coinsurance plus any balances
Eyewear	Frames/Lenses	$40 reimbursement per Member, per year	N/A	N/A	

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		Network Benefits (1)	Network Benefits (1)	Network Benefits	Out-of-Network Benefits (2)
Outpatient	Medical exams, telemedicine and online visits, consultations, medical treatments	Visit Copayment or Specialty Visit Copayment	Visit Copayment or Specialty Visit Copayment	Standard Deductible	Standard Deductible and Coinsurance plus any balances
	Injections (except allergy injections)	You pay $0	Visit Copayment or Specialty Visit Copayment	Standard Deductible	Standard Deductible and Coinsurance plus any balances
	Allergy Injections	You pay $0	You pay $0	Standard Deductible	Standard Deductible and Coinsurance plus any balances
	Surgery and anesthesia	You pay $0	You pay $0 at Site of Service providers. Otherwise, Standard Deductible.	Standard Deductible	Standard Deductible and Coinsurance plus any balances
	Laboratory tests (including allergy testing)	You pay $0	You pay $0 at Site of Service providers. Otherwise, Standard Deductible.	Standard Deductible	Standard Deductible and Coinsurance plus any balances
	X-ray tests (including ultrasound)	You pay $0	You pay $0 at Site of Service providers. Otherwise, Standard Deductible.	Standard Deductible	Standard Deductible and Coinsurance plus any balances
	MRA, MRI, PET, SPECT, CT Scan, and CTA	You pay $0	You pay $0 at Site of Service providers. Otherwise, Standard Deductible.	Standard Deductible	Standard Deductible and Coinsurance plus any balances
	Medical Supplies, Chemotherapy, Infusion Therapy, and Drugs	You pay $0	Standard Deductible	Standard Deductible	Standard Deductible and Coinsurance plus any balances
	Maternity Care	You pay no visit copayment for prenatal or postpartum office visits. Your share of the cost for delivery of a baby is the same as shown for "Inpatient Services" or "Outpatient Facility Care."	You pay no visit copayment for prenatal or postpartum office visits. Your share of the cost for delivery of a baby is the same as shown for "Inpatient Services" or "Outpatient Facility Care."	Standard Deductible	Standard Deductible and Coinsurance plus any balances

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		Network Benefits (1)	Network Benefits (1)	Network Benefits	Out-of-Network Benefits (2)
Emergency Room and Urgent Care	Use of the emergency room (copayment waived if you are admitted)	Emergency Room Copayment	Emergency Room Copayment	Standard Deductible	Standard Deductible and Coinsurance plus any balances
	Use of an Urgent Care Facility	Urgent Care Facility Copayment	Urgent Care Facility Copayment	Standard Deductible	Standard Deductible and Coinsurance plus any balances
	Physician's fee, surgery, MRA, MRI, PET, SPECT, CT Scan, CTA, medical supplies and drugs	You pay $0	Standard Deductible	Standard Deductible	Standard Deductible and Coinsurance plus any balances
	Laboratory and x-ray tests	You pay $0	Standard Deductible	Standard Deductible	Standard Deductible and Coinsurance plus any balances
	Ambulance Services - must be medically necessary	You pay $0	Standard Deductible	Standard Deductible	
Outpatient Physical Rehab	Physical, Occupational and Speech Therapy	Specialty Visit Copayment, up to a combined maximum of 60 visits per Member, per year	Visit Copayment, up to a combined maximum of 60 visits per Member, per year	Standard Deductible, up to a combined maximum of 60 visits per Member, per plan year (5)	Standard Deductible and Coinsurance plus any balances
	Cardiac Rehabilitation Visits	Specialty Visit Copayment	Visit Copayment	Standard Deductible	Standard Deductible and Coinsurance plus any balances
	Chiropractic Care	Specialty Visit Copayment, up to 12 visits per Member, per year	Visit Copayment, Unlimited Visits	Standard Deductible, Unlimited visits	Standard Deductible and Coinsurance plus any balances
	X-ray tests performed by a chiropractor	You pay $0	Standard Deductible	Standard Deductible	Standard Deductible and Coinsurance plus any balances
	Acupuncture	N/A	Visit Copayment, Unlimited visits	Standard Deductible, Unlimited visits	Standard Deductible and Coinsurance plus any balances
Home Care	Physician Services (medical exams, injections, medical treatments, surgery and anesthesia, telemedicine and online visits)	Visit Copayment or Specialty Visit Copayment	Visit Copayment or Specialty Visit Copayment	Standard Deductible	Standard Deductible and Coinsurance plus any balances
	Home Health Agency Services	You pay $0	Standard Deductible	Standard Deductible	Standard Deductible and Coinsurance plus any balances
	Hospice	You pay $0	You pay $0	Standard Deductible	Standard Deductible and Coinsurance plus any balances

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		Network Benefits (1)	Network Benefits (1)	Network Benefits	Out-of-Network Benefits (2)
Behavioral Health Care	Outpatient Behavioral Healthcare (Mental Health, Substance Use Care, and Applied Behavioral Analysis)	Visit Copayment or Specialty Visit Copayment, Unlimited visits	Visit Copayment or Specialty Visit Copayment, Unlimited visits	Standard Deductible, Unlimited visits	Standard Deductible and Coinsurance plus any balances
	Inpatient Behavioral Healthcare (Mental Health and Substance Use Care)	You pay $0	Standard Deductible	Standard Deductible	Standard Deductible and Coinsurance plus any balances
Prescription Drugs	Prescription Drugs	Retail Pharmacy: $10 generic, $20 preferred brand-name, $45 non-preferred brand-name for up to 34-day supply through CVS Caremark's participating retail pharmacies. Maintenance Choice: $10 generic, $20 preferred brand-name, $45 non-preferred brand-name for up to 90-day supply through CVS Caremark's Mail Service Pharmacy or at a CVS Pharmacy.	Retail Pharmacy: $10 generic, $20 preferred brand-name, $45 non-preferred brand-name for up to 34-day supply through CVS Caremark's participating retail pharmacies. Maintenance Choice: $10 generic, $20 preferred brand-name, $45 non-preferred brand-name for up to 90-day supply through CVS Caremark's Mail Service Pharmacy or at a CVS Pharmacy.	In Network: Standard Deductible. Out-of-Network: Standard Deductible and Coinsurance, plus any balances. (6)	
Resource Links		Medical Benefit Cost Sharing Prescription Benefit Summary	Medical Benefit Cost Sharing Site of Service Info Prescription Benefit Summary	Medical Benefit Cost Sharing Lumenos RX Info	

(1) Referrals are not required for care provided within the Access Blue New England Network.

(2) Benefits are limited to the Maximum Allowable Amount (MAA). Under Out-of-Network Benefits, You may be responsible for paying the difference between the MAA and charge. Self-referred care may require preauthorization/precertification from Anthem.

(3) If you are enrolled at the 2-person or family level, eligible expenses incurred by you or any of your enrolled family members count toward satisfying the entire 2-person/family deductible and/or coinsurance.

(4) The Out-of-Pocket Limit includes all Deductibles, Coinsurance, and Copayments You pay during a year for medical and prescription expenses under this medical plan and Your HealthTrust prescription benefit program. It does not include your premium, amounts over the Maximum Allowed Amount, penalties, or charges for noncovered services. Once the combined Out-of-Pocket Limit is satisfied, You will not have to pay additional Deductibles, Coinsurance, or Copayments for the rest of the year.

(5) Any combination of Network Benefits and Out-of-Network Benefits counts toward this limit.

(6) As required by law, “Preventive Care” pharmacy services are covered in full when furnished by a Network Pharmacy with a prescription from Your physician. In addition, as permitted by IRS Notice 2019-45, covered prescription insulin drugs for individuals diagnosed with diabetes are not subject to any Standard Deductible and/or Standard Coinsurance, but are subject to cost sharing of up to $30 for each 30-day supply.

Please note that throughout this chart any reference to year means plan year. Plan year is July 1 through June 30.

This chart is intended for summary purposes only. Details of coverage are set forth in separate documents, which govern these plans.