Your Anthem Benefits

Kimball Electronics

Kimball Electronics, Inc.

2700 CDHP Health Savings Account

Summary of Benefits, Effective 01/01/2025

Covered Benefits	In-Network You Pay:	Out-of-Network You Pay:
Deductible (Single/Family) Family coverage requires the family deductible to be met before coinsurance applies. The single deductible does not apply to family coverage.	$2,700 Single / $5,400 Family Only In-Network expenses apply to the In-Network deductible.	$5,400 Single / $10,800 Family Only Out-of-Network expenses apply to the Out-of-Network deductible.
Out-of-Pocket Limit (Single/Family) once deductible is met this applies to Prescription Drugs Only	$6,000 Single / $12,000 Family	
Lifetime Maximum	Unlimited	
Physician Office Services Primary Care Physician /Specialty Care Physician Including: • Surgeries performed in office setting • Allergy injections and serum	0% after deductible Plan pays 100%	0% after Out-of-Network deductible Plan pays 100%
Preventive Care Services Routine preventive care as defined by the Plan, such as routine physical exams, well-baby exams, vision exams, mammograms, pap test, PSA test, immunizations and related lab services. • Physician Office Visits • Other Outpatient Services at Hospital/Alternative Care Facility	Covered at 100%	Covered at 100%
Maternity Care Services (Spouse Only) Initial office visit to confirm pregnancy All subsequent prenatal visits, postnatal visits and physician's delivery charges (total maternity fee)	0% after deductible Plan pays 100% 0% after deductible Plan pays 100%	0% after Out-of-Network deductible Plan pays 100% 0% after Out-of-Network deductible Plan pays 100%
Emergency and Urgent Care • Hospital Emergency Room Services • Urgent Care Center Services • Ambulance Services	0% after deductible Plan pays 100%	0% after Out-of-Network deductible Plan pays 100%
Inpatient and Outpatient Professional Services Including but not limited to: • Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and Administration of General Anesthesia	0% after deductible Plan pays 100%	0% after Out-of-Network deductible Plan pays 100%
Inpatient Hospital Facility Services • Semi-Private Room and Board • Diagnostic/Therapeutic Lab and X-ray • Operating and Recovery Room • Radiation Therapy and Chemotherapy • Anesthesia and Inhalation Therapy	0% after deductible Plan pays 100%	0% after Out-of-Network deductible Plan pays 100%
Inpatient Services at Other Health Care Facilities • Skilled Nursing 120 days maximum • Sub-Acute Facilities	0% after deductible Plan pays 100%	0% after Out-of-Network deductible Plan pays 100%
Outpatient Surgery Hospital / Alternative Care Facility • Surgery and administration of general anesthesia	0% after deductible Plan pays 100%	0% after Out-of-Network deductible Plan pays 100%

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Other Outpatient Services (including but not limited to): • Non-Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services • Home Care Services (Network/Non-network combined)	0% after deductible Plan pays 100%	0% after Out-of-Network deductible Plan pays 100%
Durable Medical Equipment and Orthotics Pre-certification may be required (see pre-cert list)	0% after deductible Plan pays 100%	0% after Out-of-Network deductible Plan pays 100%
Outpatient Therapy Services Physician Office Visits and Other Outpatient Services at Hospital/Alternative Care Facility • Rehabilitation Services, Physical Therapy, Occupational Therapy – 30 visits per calendar year (not combined with any other therapy) • Manipulation Therapy – 20 visits per calendar year • Speech Therapy - 30 visits per calendar year (not combined with any other therapy)	0% after deductible Plan pays 100%	0% after Out-of-Network deductible Plan pays 100%
Laboratory and Radiology Services: **(includes preadmission testing)** • Physician's Office • Inpatient Facility • Outpatient Facility • Independent X-Ray and/or Lab Facility	0% after deductible Plan pays 100%	0% after Out-of-Network deductible Plan pays 100%
Behavioral Health Services: **Mental Health** • Inpatient Facility Services • Outpatient Facility Services • Physician Office Visits • Other Outpatient Services at Hospital/Alternative Care Facility	0% after deductible Plan pays 100%	0% after Out-of-Network deductible Plan pays 100%
Behavioral Health Services: **Substance Abuse** • Inpatient Facility Services • Outpatient Facility Services • Physician Office Visits • Other Outpatient Services at Hospital/Alternative Care Facility	0% after deductible Plan pays 100%	0% after Out-of-Network deductible Plan pays 100%

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Covered Benefits	On the Preventive Drug List you pay:	Not on the Preventive Drug List you pay:
Prescription Drugs:		
• Network Retail Pharmacies: (30-day supply)	10% for generic drugs	10% after deductible
	20% for preferred brand-name drugs	20% after deductible
	30% for non-preferred brand-name drugs	30% after deductible
• Mail Service**: (90-day Supply)	10% for generic drugs	10% after deductible
	20% for preferred brand-name drugs	20% after deductible
	30% for non-preferred brand-name drugs	30% after deductible
**Specialty drugs must be obtained through the Accredo Specialty pharmacy		**- Prescription drugs not on the preventive drug list are paid at 100% after the out-of-pocket limit is met ($6,000 Single / $12,000 Family).**

Regarding Prescription Drugs:
- Administered by Express Scripts
- Prescription drugs on the preventive drug list do not apply towards the calendar year deductible. They do apply towards the out-of-pocket limit and are covered at 100% when the out-of-pocket limit is met.
- Prescription drugs not on the preventive drug list are applied towards the calendar year deductible and out-of-pocket limit.
- Specialty drugs are applied towards the calendar year deductible and out-of-pocket limit. You will pay 20% after deductible is met. Specialty drugs are paid at 100% after the out-of-pocket limit is met.
- The initial fill of a specialty drug will be allowed at retail. All subsequent fills must be obtained through Accredo.

Footnotes:
Regarding In-Network and Out-of-Network Services*:*
- *Deductible applies to out-of-pocket limit.*
- *Once the plan's out-of-pocket maximum is reached, the plan pays 100% of eligible charges for the remainder of the plan year*
- *Emergency services are medical, psychiatric, surgical, hospital and related health care services and testing, including ambulance service, which are required to treat a sudden, unexpected onset of bodily injury or serious sickness.*

Regarding In-Network Services*:*
- *All services must be provided by one of the preferred providers on our list in order to be covered.*

Regarding Out-of-Network Services*:*
- *Your out-of-pocket costs will be higher than with a preferred provider.*
- *All out-of-network hospital admissions must be pre-certified and are subject to medical review. A penalty applies to admissions which are not precertified. Non-approved admissions/days result in denial of benefits. The precertification penalty or cost of denied benefits does not apply to deductible or out-of-pocket maximum.*
- *Out of network services are subject to reasonable and customary charge limitations*