Your summary of benefits

Anthem

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Century Preferred PPO $35/$5000/20%/$8150 Rx 30% to $10/30% to $80/30% to $250/30% to $500 V

Your Network: Century Preferred

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$5,000 person / $10,000 family	$15,000 person / $30,000 family
Overall Out-of-Pocket Limit	$8,150 person / $16,300 family	$24,450 person / $48,900 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. Your copays, coinsurance and deductible count toward your out of pocket limit(s). 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 $60 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*	$35 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Specialist Care *virtual and office*	$60 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Other Practitioner Visits		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Routine Maternity Care (Prenatal and Postnatal)	No charge	50% coinsurance after medical deductible is met
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$35 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Manipulation Therapy *Coverage is limited to 20 visits per benefit period.*	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Acupuncture *Coverage is limited to services provided for pain management.*	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Other Services in an Office		
Allergy Testing	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Prescription Drugs *Dispensed in the office*	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Surgery	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Preventive care / screenings / immunizations	No charge	50% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	50% coinsurance after medical deductible is met
Diagnostic Services **Lab**		
Office	$60 copay per visit medical deductible does not apply‡	50% coinsurance after medical deductible is met
Freestanding/Site of Service Lab	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	50% 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
X-Ray		
Office	$60 copay per visit medical deductible does not apply‡	50% coinsurance after medical deductible is met
Freestanding/Site of Service Radiology Center	$60 copay per visit medical deductible does not apply‡	50% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans Member cost share will not exceed $375 copayment maximum for MRI, MRA, CAT, CTA, PET, and SPECT scans, per member per benefit period.*		
Office	$60 copay per visit medical deductible does not apply‡	50% coinsurance after medical deductible is met
Freestanding/Site of Service Radiology Center	$60 copay per visit medical deductible does not apply‡	50% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	$75 copay per visit after medical deductible is met	50% coinsurance after medical deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	20% coinsurance after medical deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after medical deductible is met	Covered as In-Network
Ambulance	20% coinsurance after medical deductible is met	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Mental Health and Substance Abuse Care at a Facility		
Facility Fees	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Doctor Services	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Ambulatory Surgical Center/Site of Service Provider	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Doctor and Other Services		
Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Ambulatory Surgical Center/Site of Service Provider	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Physician and other services *including surgeon fees*	20% coinsurance after medical deductible is met	50% 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. Home Health Care Services are subject to an annual deductible of $50 per member. This plan has a separate Home Health Care Deductible and it does not apply toward any other Deductible for Covered Services in this Plan.*	20% coinsurance medical deductible does not apply	20% coinsurance after a $50 deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for physical and occupational therapies is limited to 20 visits combined per benefit period. Coverage for speech therapy is limited to 20 visits per benefit period.*		
Office	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Pulmonary rehabilitation *office and outpatient hospital*	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Cardiac rehabilitation *office and outpatient hospital* *Coverage is limited to 36 visits per benefit period.*	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Chemo/Radiation Therapy *office and outpatient hospital*	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.*	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Inpatient Hospice	No charge after medical deductible is met	50% coinsurance after medical deductible is met
Durable Medical Equipment	50% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	50% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Hearing Aids *Coverage is limited to 1 item per ear every 2 benefit periods.*	50% coinsurance after medical deductible is met	50% 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:** ***Advantage 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.*		
Tier 1 - Typically Generic	30% coinsurance up to $10 per prescription (retail) and 30% coinsurance up to $25 per prescription (home delivery)	50% coinsurance (retail and home delivery)
Tier 2 – Typically Preferred Brand	30% coinsurance up to $80 per prescription (retail) and 30% coinsurance up to $240 per prescription (home delivery)	50% coinsurance (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand	30% coinsurance up to $250 per prescription (retail) and 30% coinsurance up to $750 per prescription (home delivery)	50% coinsurance (retail and home delivery)
Tier 4 - Typically Specialty (brand and generic)	30% coinsurance up to $500 per prescription (retail and home delivery)	50% coinsurance (retail and 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. Adult and children's vision services count towards your out of pocket limit.		
Pediatric Vision exam (for dependent children under age 26) *Limited to 1 exam per benefit period.*	$60 copay	50% coinsurance
Frames *Limited to 1 unit every 2 benefit periods.*	No charge	50% coinsurance
Lenses *Limited to 1 unit every 2 benefit periods.*	No charge	50% coinsurance
Elective Contact Lenses *Limited to 1 unit every 2 benefit periods.*	No charge	50% coinsurance
Non-Elective Contact Lenses *Limited to 1 unit every 2 benefit periods.*	No charge	50% coinsurance
Adult Vision exam (for subscriber and spouse members age 19 and older) *Limited to 1 exam per benefit period.*	$60 copay	Reimbursed Up to $48
Frames *Limited to 1 unit every 2 benefit periods.*	$140 Allowance	Reimbursed Up to $52
Lenses *Limited to 1 unit every 2 benefit periods combined with OON Coverage. OON Reimbursement: Single* Reimbursed Up to $32*, Bifocal* Reimbursed Up to $47*, Trifocal* Reimbursed Up to $66*.*	No charge	Receives Reimbursement
Elective Contact Lenses *Limited to 1 unit every 2 benefit periods.*	$130 Allowance	Reimbursed Up to $84
Non-Elective Contact Lenses *Limited to 1 unit every 2 benefit periods.*	No charge	Reimbursed Up to $210

Notes:

- 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.
- ‡ 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 Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

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(TTY/TDD: 711)

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