Your summary of benefits

Anthem

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Century Preferred PPO HSA $3000/20%/$5000 Rx 30% to $10/30% to $80/30% to $250/30% to $500 Prev Rx

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	$3,000 person / $6,000 family	$3,000 person / $6,000 family
Overall Out-of-Pocket Limit	$5,000 person / $8,150 family	$15,000 person / $30,000 family
The family deductible and out-of-pocket limit are non-embedded, meaning the cost shares of all family members apply to one family deductible and one family out-of-pocket limit. The per person deductible and per person out-of-pocket limit apply to individuals enrolled under single-only coverage. 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 No charge after deductible is met.*		
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 20% coinsurance after deductible is met; and 20% coinsurance after deductible is met for covered Specialist Care.*		
Primary Care (PCP) and Mental Health and Substance Abuse Care *virtual and office*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Specialist Care *virtual and office*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	No charge	50% coinsurance after 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.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 20 visits per benefit period.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Acupuncture *Coverage is limited to services provided for pain management.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Services in an Office		
Allergy Testing	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Surgery	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	50% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	50% coinsurance after deductible is met
Diagnostic Services **Lab**		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding/Site of Service Lab	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
X-Ray		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding/Site of Service Radiology Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Freestanding/Site of Service Radiology Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency Room Facility Services	20% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	Covered as In-Network
Ambulance	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse Care at a Facility		
Facility Fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Ambulatory Surgical Center/Site of Service Provider	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and Other Services		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Ambulatory Surgical Center/Site of Service Provider	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Physician and other services *including surgeon fees*	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Home Health Care *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	20% coinsurance after deductible is met	20% coinsurance after deductible is met
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 deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Pulmonary rehabilitation *office and outpatient hospital*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation *office and outpatient hospital* *Coverage is limited to 36 visits per benefit period.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Chemo/Radiation Therapy *office and outpatient hospital*	20% coinsurance after deductible is met	50% coinsurance after 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 deductible is met	50% coinsurance after deductible is met
Inpatient Hospice	No charge after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Hearing Aids *Coverage is limited to 1 item per ear every 2 benefit periods.*	50% coinsurance after deductible is met	50% coinsurance after 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	Combined with In-Network medical deductible	Combined with Non-Network medical deductible
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.*		
Preventive Drugs *Your In-Network Pharmacy deductible is waived for 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	30% coinsurance up to $10 per prescription after deductible is met (retail) and 30% coinsurance up to $25 per prescription after deductible is met (home delivery)	50% coinsurance after deductible is met (retail and home delivery)
Tier 2 – Typically Preferred Brand	30% coinsurance up to $80 per prescription after deductible is met (retail) and 30% coinsurance up to $240 per prescription after deductible is met (home delivery)	50% coinsurance after deductible is met (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand	30% coinsurance up to $250 per prescription after deductible is met (retail) and 30%	50% coinsurance after deductible is met (retail and home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
	coinsurance up to $750 per prescription after deductible is met (home delivery)	
Tier 4 - Typically Specialty (brand and generic)	30% coinsurance up to $500 per prescription after deductible is met (retail and home delivery)	50% coinsurance after deductible is met (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. Adult and children's vision services count towards your out of pocket limit.		
Child Vision exam *Limited to 1 exam per benefit period.*	No charge	50% coinsurance after deductible is met
Adult Vision exam *Limited to 1 exam per benefit period.*	No charge	50% coinsurance after deductible is met

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.

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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