# Your summary of benefits

Anthem

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Century Preferred PPO HSA $5000/20%/$7000 E 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** | $5,000 person / $10,000 family | $5,000 person / $10,000 family |
| **Overall Out-of-Pocket Limit** | $7,000 person / $14,000 family | $21,000 person / $42,000 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.<br>Your copays, coinsurance and deductible count toward your out of pocket limit(s).<br>In-Network and Non-Network deductibles are combined and accumulate toward each other; however In-Network and Non-Network out-of-pocket limit amounts accumulate separately 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 No charge after deductible is met; and $60 copay per visit after deductible is met for covered Specialist Care.* | | |
| **Primary Care (PCP) and Mental Health and Substance Abuse Care** *virtual and office* | $40 copay per visit after deductible is met | 50% coinsurance after deductible is met |
| **Specialist Care** *virtual and office* | $60 copay per visit after deductible is met | 50% coinsurance after deductible is met |
| **Other Practitioner Visits** | | |

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| 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 deductible is met |
| **Retail Health Clinic** *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.* | $40 copay per visit after deductible is met | 50% coinsurance after deductible is met |
| **Manipulation Therapy**<br>*Coverage is limited to 20 visits per benefit period.* | $60 copay per visit after deductible is met | 50% coinsurance after deductible is met |
| **Acupuncture**<br>*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** | $60 copay per visit 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**<br>**Lab** | | |
| Office | $60 copay per visit 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 | $60 copay per visit after deductible is met‡ | 50% coinsurance after deductible is met |
| Freestanding/Site of Service Radiology Center | $60 copay per visit after deductible is met‡ | 50% coinsurance after deductible is met |
| Outpatient Hospital | 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 |
|---|---|---|
| **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 after deductible is met‡ | 50% coinsurance after deductible is met |
| Freestanding/Site of Service Radiology Center | $60 copay per visit 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** *includes doctor services. Additional charges may apply depending on the care provided.* | $50 copay per visit 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 |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|
| **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 |
| **Home Health Care**<br>*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.*<br>*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 | $30 copay per visit after deductible is met | 50% coinsurance after deductible is met |
| Outpatient Hospital | $30 copay per visit 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*<br>*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)**<br>*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** | 50% 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 |
|---|---|---|
| *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.* | | |
| **Hearing Aids**<br>*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**<br>**Network:** ***Advantage Network***<br>**Drug List:** ***Essential*** *Drugs not included on the Essential drug list will not be covered.* | | |
| **Day Supply Limits:**<br>**Retail Pharmacy** *30 day supply (cost shares noted below)*<br>**Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).*<br>**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.*<br>**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 | 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 |
|---|---|---|
| | (retail) and 30% coinsurance up to $240 per prescription after deductible is met (home delivery) | |
| **Tier 3 - Typically Non-Preferred Brand** | 30% coinsurance up to $250 per prescription after deductible is met (retail) and 30% coinsurance up to $750 per prescription after deductible is met (home delivery) | 50% coinsurance after deductible is met (retail and 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**<br>*Limited to 1 exam per benefit period.* | No charge | 50% coinsurance after deductible is met |
| **Adult Vision exam**<br>*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.
- ‡ 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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If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (888) 224-4896

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**(TTY/TDD: 711)**

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## Language Access Services:

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