Your summary of benefits

Anthem® BlueCross and BlueShield

Your Plan: Anthem Century Preferred PPO $15/$0/$0/$50 Rx $10/$20

Your Network: Century Preferred

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.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$0 person / $0 family	$200 person / $600 family
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.*	$6,600 person / $13,200 family	$1,200 person / $1,600 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible. Included are the preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.*	No charge	20% coinsurance after medical deductible is met
Doctor Home and Office Services		
Primary Care Visit to treat an injury or illness *All services performed in the office are included in the office copay.*	$15 copay per visit	20% coinsurance after medical deductible is met
Specialist Care Visit *All services performed in the office are included in the office copay.*	$20 copay per visit	20% coinsurance after medical deductible is met
Routine Prenatal Care *Initial visit subject to $20 copay*	No charge	20% coinsurance after medical deductible is met

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Routine Postnatal Care	No charge	20% coinsurance after medical deductible is met
Other Practitioner Visits:		
Retail Health Clinic	$15 copay per visit	20% coinsurance after medical deductible is met
On-line Visit *Live Health Online is the preferred telehealth solutions (www.livehealthonline.com)*	No charge	20% coinsurance after medical deductible is met
Chiropractic *Coverage is limited to 50 combined visits with pt,ot,st per benefit period. Limit is combined In-Network and Non-Network.*	No charge	20% coinsurance after medical deductible is met
Acupuncture *Coverage is limited to 50 visits per benefit period combined with In-Network and Non-Network.*	No Charge	20% coinsurance after medical deductible is met
Other Services in an Office:		
Allergy Testing	$20 copay per visit	20% coinsurance after medical deductible is met
Allergy Injections/Treatment *Maximum allowed of 80 visits within 3 years*	No charge	20% coinsurance After medical deductible is met
Chemo/Radiation Therapy	No charge	20% coinsurance after medical deductible is met
Dialysis/Hemodialysis	No charge	20% coinsurance after medical deductible is met
Prescription Drugs *For the drugs itself dispensed in the office through infusion/injection.*	No charge	20% coinsurance after medical deductible is met

Office *All services performed in the office are included in the office copay.*	No charge	20% coinsurance after medical deductible is met
Freestanding/Site-of-Service Lab	No charge	20% coinsurance after medical deductible is met
Outpatient Hospital	No charge	20% coinsurance after medical deductible is met
X-Ray:		
Office *All services performed in the office are included in the office copay.* *Breast ultrasound cannot exceed $20 copay.*	No charge	20% coinsurance after medical deductible is met
Freestanding/Site-of-Service Radiology Center	No charge	20% coinsurance after medical deductible is met
Outpatient Hospital	No charge	20% coinsurance after medical deductible is met
Advanced Diagnostic Imaging: *Imaging services include MRI, MRA, CAT, CTA, PET, and SPECT scans.*		
Office *All services performed in the office are included in the office copay.*	No charge	20% coinsurance after medical deductible is met
Freestanding/Site-of-Service Radiology Center	No charge	20% coinsurance after medical deductible is met
Outpatient Hospital	No charge	20% coinsurance after medical deductible is met

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Emergency and Urgent Care		
Urgent Care	$25 copay per visit	Not Covered
Emergency Room Facility Services	$50 copay per visit	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	Covered as In-Network
Ambulance Transportation	No charge	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit and Online Visit	No charge	20% coinsurance after medical deductible is met
Facility visit:		
Facility Fees	No charge	20% coinsurance after medical deductible is met
Doctor Services	No charge	20% coinsurance after medical deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	No charge	20% coinsurance after medical deductible is met
Freestanding Surgical Center	No charge	20% coinsurance after medical deductible is met

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Doctor and Other Services:		
Hospital	No charge	20% coinsurance after medical deductible is met
Freestanding Surgical Center	No charge	20% coinsurance after medical deductible is met
Hospital Stay (all Inpatient stays including Maternity, Mental/Behavioral Health, Substance Abuse, Infertility, Human Organ and Tissue Transplant services):		
Facility fees (for example, room & board)	No charge	20% coinsurance after medical deductible is met
Doctor and other services	No charge	20% coinsurance after medical deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 200 visits per benefit period with 80 of the visits eligible as home health aide visits. Limit is combined In-Network and Non-Network Two skilled nursing visits per week are required to be eligible for coverage. Custodial Care is not covered.*	No charge	$50 deductible then 20% coinsurance
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for rehabilitative and habilitative physical therapy, occupational therapy, speech therapy and chiropractic care combined is limited to 50 visits per benefit period. Limit is combined across professional visits and outpatient facilities. Limit is combined In –Network and Non-Network*	No charge	20% coinsurance after medical deductible is met
Outpatient Hospital *Coverage for rehabilitative and habilitative physical therapy, occupational therapy, speech therapy, and chiropractic care combined is limited to 50 visits per benefit period. Limit is combined across professional visits and outpatient facilities. Limit is combined In –Network and Non-Network*	No charge	20% coinsurance after medical deductible is met

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Cardiac rehabilitation		
Office *Coverage is limited to 36 visit(s) per episode. Limit is combined In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits.*	No charge	20% coinsurance after medical deductible is met
Outpatient Hospital *Coverage is limited to 36 visit(s) per episode. Limit is combined In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits.*	No charge	20% coinsurance after medical deductible is met
Skilled Nursing Care (in a facility) *Coverage is limited to 120 days per benefit period. Limit is combined In-Network and Non-Network.*	No charge	20% coinsurance after medical deductible is met
Inpatient Hospice *60 day maximum*	$200 copay	20% coinsurance after medical deductible is met
Outpatient Hospice	No Charge	20% coinsurance after medical deductible is met
Home Hospice *Coverage is combined with Home Health Care limits of 200 visits per benefit period. Limit is combined In-Network and Non-Network*	No Charge	$50 deductible then 20% coinsurance
Durable Medical Equipment *Coverage for hearing aids is limited to 1 per ear every 2 years.*	No charge	20% coinsurance after medical deductible is met
Prosthetic Devices *Mandatory coverage of a wig if prescribed by a licensed oncologist for a patient who suffers hair loss as a result of chemotherapy.* *Foot Orthotics are not covered.*	No charge	20% coinsurance after medical deductible is met

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Notes:

The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.

- Effective 7/1/2022, covered services related to infertility must be rendered by a Connecticut participating provider. Infertility services performed by any provider other than a participating provider located within Connecticut are considered non-covered services.
- For additional information on this plan, please visit sbc.anthem.com to obtain a "Summary of Benefit Coverage".
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- If your plan includes out of network benefits and you use a non-participating provider, you are responsible for any difference between the covered expense and the actual non-participating providers charge. When receiving care from providers out of network, members may be subject to balance billing in addition to any applicable copayments, coinsurance and/or deductible. This amount does not apply to the out of network out of pocket limit.

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