

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: Capital Area Health: Anthem Century Preferred PPO

Your Network: Century Preferred

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge
Mental Health & Substance Use Disorder Services	No charge
Specialist care	No charge

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$0 person / \$0 family	\$200 person / \$600 family
Overall Out-of-Pocket Limit	\$6,600 person / \$13,200 family	\$1,200 person / \$1,600 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.

All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit (excluding Non-Network Human Organ and Tissue Transplant (HOTT), Cellular and Gene Therapy services).

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).*

Primary Care (PCP) <i>virtual and office</i>	virtual -No charge office -\$15 copay per visit	20% coinsurance after deductible is met
Mental Health and Substance Use Disorder Services <i>virtual and office</i>	No charge	20% coinsurance after deductible is met
Specialist Care <i>virtual and office</i>	virtual -No charge office -\$20 copay per visit	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><u>Other Practitioner Visits</u></p> <p>Routine Maternity Care Prenatal <i>All office visit copayments count towards the same 1 visit limit.</i></p> <p>Postnatal</p> <p>Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i></p> <p>Manipulation Therapy <i>Coverage for rehabilitative and habilitative physical therapy, occupational therapy, speech therapy, and manipulative treatment is limited to 50 visits combined per benefit period.</i></p> <p>Acupuncture <i>Coverage is limited to 50 visits per benefit period.</i></p>	<p>\$20 copay per visit for the first 1 visit</p> <p>No charge</p> <p>\$15 copay per visit</p> <p>No charge</p> <p>No charge</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>
<p><u>Other Services in an Office</u></p> <p>Allergy Testing <i>When Allergy injections are billed separately by network providers, the member is responsible for No charge. When billed as part of an office visit, there is no additional cost to the member for the injection.</i></p> <p>Prescription Drugs <i>Dispensed in the office</i></p> <p>Surgery</p>	<p>\$20 copay per visit</p> <p>No charge</p> <p>No charge</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>
<p>Preventive care / screenings / immunizations</p>	<p>No charge</p>	<p>20% coinsurance after deductible is met</p>
<p>Preventive Care for Chronic Conditions <i>per IRS guidelines</i></p>	<p>No charge</p>	<p>20% coinsurance after deductible is met</p>
<p><u>Diagnostic Services</u></p> <p>Lab</p> <p>Office</p> <p>Freestanding/Site of Service Lab</p> <p>Outpatient Hospital</p>	<p>No charge</p> <p>No charge</p> <p>No charge</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>X-Ray</p> <p>Office</p> <p>Freestanding/Site of Service Radiology Center</p> <p>Outpatient Hospital</p>	<p>No charge</p> <p>No charge</p> <p>No charge</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>
<p>Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i></p> <p>Office</p> <p>Freestanding/Site of Service Radiology Center</p> <p>Outpatient Hospital</p>	<p>No charge</p> <p>No charge</p> <p>No charge</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>
<p><u>Emergency and Urgent Care</u></p> <p>Urgent Care <i>includes doctor services. Additional charges may apply depending on the care provided.</i></p> <p>Emergency Room Facility Services <i>Your copay will be waived if admitted.</i></p> <p>Emergency Room Doctor and Other Services</p> <p>Ambulance <i>Authorized Non-Network non-emergency ambulance services are limited to an Anthem maximum payment of \$50,000 per trip.</i></p>	<p>\$25 copay per visit</p> <p>\$50 copay per visit</p> <p>No charge</p> <p>No charge</p>	<p>Not covered</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p>Outpatient Mental Health and Substance Use Disorder Services at a Facility</p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>No charge</p> <p>No charge</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>
<p><u>Outpatient Surgery</u></p> <p>Facility Fees</p> <p>Hospital</p>	<p>No charge</p>	<p>20% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Ambulatory Surgical Center/Site of Service Provider</p> <p>Physician and other services <i>including surgeon fees</i></p> <p>Hospital</p> <p>Ambulatory Surgical Center/Site of Service Provider</p>	<p>No charge</p> <p>No charge</p> <p>No charge</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>
<p><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u></p> <p>Facility Fees</p> <p>Physician and other services <i>including surgeon fees</i></p>	<p>No charge</p> <p>No charge</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>
<p>Home Health Care <i>Coverage is limited to 200 visits per benefit period. 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.</i></p>	<p>No charge</p>	<p>20% coinsurance after a \$50 deductible is met</p>
<p>Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies.</i> <i>Coverage for physical, occupational and speech therapies and manipulative treatment is limited to 50 visits combined per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>No charge</p> <p>No charge</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>
<p>Pulmonary rehabilitation <i>office and outpatient hospital</i></p>	<p>No charge</p>	<p>20% coinsurance after deductible is met</p>
<p>Cardiac rehabilitation <i>office and outpatient hospital</i> <i>Coverage is limited to 36 visits per episode.</i></p>	<p>No charge</p>	<p>20% coinsurance after deductible is met</p>
<p>Dialysis/Hemodialysis <i>office and outpatient hospital</i></p>	<p>No charge</p>	<p>20% coinsurance after deductible is met</p>
<p>Chemo/Radiation Therapy <i>office and outpatient hospital</i></p>	<p>No charge</p>	<p>20% coinsurance after deductible is met</p>
<p>Skilled Nursing Care (facility) <i>Coverage is limited to 120 days per benefit period.</i></p>	<p>No charge</p>	<p>20% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Inpatient Hospice <i>Coverage is limited to 60 days per benefit period.</i>	\$200 copay per admission	20% coinsurance after deductible is met
Durable Medical Equipment	No charge	20% coinsurance after deductible is met
Prosthetic Devices <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	No charge	20% coinsurance after deductible is met
Hearing Aids <i>Coverage is limited to 1 item per ear every 2 years.</i>	No charge	20% 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	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: <i>Base Network</i> Drug List: <i>National</i>		
Day Supply Limits: Retail Pharmacy 34 day supply (cost shares noted below) Home Delivery Pharmacy 100 day supply (maximum cost shares noted below). Maintenance medications are available through CarelonRx Pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service. Specialty Pharmacy 34 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	\$10 copay per prescription (retail) and \$0 copay per prescription (home delivery)	20% coinsurance (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand	\$20 copay per prescription (retail) and \$0 copay per prescription (home delivery)	20% coinsurance (retail) and Not covered (home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Tier 3 - Typically Non-Preferred Brand/Specialty Drugs	\$20 copay per prescription (retail) and \$0 copay per prescription (home delivery)	20% coinsurance (retail) and Not covered (home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<i>This is a brief outline of your vision coverage. Adult vision services count towards your out-of-pocket limit.</i>		
Adult Vision exam <i>Limited to 1 exam per benefit period.</i>	No charge	20% 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.
- Certain screening and diagnostic testing for the detection of ovarian and breast cancer are covered in full as required by state mandate.
- Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, 3D mammography, breast ultrasounds and MRIs are covered in full as required by state mandate.
- 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.

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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Questions: (888) 224-4896 or visit us at www.anthem.com

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Language Access Services:

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:

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

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

(TTY/TDD: 711)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (888) 224-4896

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (888) 224-4896:

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Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (888) 224-4896.

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Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(888) 224-4896 にお電話ください。

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(888) 224-4896로 문의하십시오.

Navajo (Diné): Díí naaltsoos biká'ígíí lahgo bína'ídiłkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj bee níl hodoonih t'áadoo báąh ilínígóó. Ata' halne'ígíí ła' bich'í' hadeesdzih nínízingo kojí' hodiilnih (888) 224-4896.

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Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: (888) 224-4896.

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Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (888) 224-4896.

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It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.