Your summary of benefits

Anthem®

Anthem® Blue Cross and Blue Shield

Your Plan: NORWICH:TOWN AND BOARD OF EDUCATION (Non Med Wrap): Anthem Century Preferred PPO PS CSV

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	$750 person / $2,000 family	$2,000 person / $6,000 family
Out-of-Pocket Limit	$2,250 person / $6,000 family	$6,000 person / $18,000 family
The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both 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.		
Preventive Care / Screening / Immunization	No charge	30% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit	$25 copay per visit deductible does not apply	30% coinsurance after deductible is met
Specialist Care Visit	$25 copay per visit deductible does not apply	30% coinsurance after deductible is met
Routine Prenatal Care	No charge	30% coinsurance after deductible is met
Routine Postnatal Care	No charge	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Other Practitioner Visits:		
Retail Health Clinic	$25 copay per visit deductible does not apply	30% coinsurance after deductible is met
Preferred On-line Visit *Includes Mental Health and Substance Abuse* *Live Health Online is the preferred telehealth solution. (www.livehealthonline.com).*	$20 copay per visit deductible does not apply	30% coinsurance after deductible is met
Other Participating Provider On-line Visit *Includes Mental Health and Substance Abuse*	$25 copay per visit deductible does not apply	30% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 50 visits per benefit period.*	$25 copay per visit deductible does not apply	30% coinsurance after deductible is met
Acupuncture	No charge	30% coinsurance after deductible is met
Other Services in an Office:		
Allergy Testing	No charge	30% coinsurance after deductible is met
Chemo/Radiation Therapy	No charge	30% coinsurance after deductible is met
Dialysis/Hemodialysis	No charge	30% coinsurance after deductible is met
Prescription Drugs - *Dispensed in the office*	No charge	30% coinsurance after deductible is met
Diagnostic Services **Lab:**		
Office	No charge	30% coinsurance after deductible is met
Freestanding/Site of Service Lab	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	30% coinsurance after 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	No charge	30% coinsurance after deductible is met
Freestanding/Site of Service Radiology Center	No charge	30% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Advanced Diagnostic Imaging:		
Office	No charge	30% coinsurance after deductible is met
Freestanding/Site of Service Radiology Center	No charge	30% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$150 copay per visit deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	Covered as In-Network
Ambulance	No charge	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	$25 copay per visit deductible does not apply	30% coinsurance after deductible is met
Facility Visit:		
Facility Fees	No charge	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Doctor Services	No charge	30% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Surgical Center	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Surgical Center	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):		
Facility Fees	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor and other services	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 200 visits per benefit period. Health Care services may be subject to an annual deductible of not more than $50 per member.*	No charge	25% coinsurance after deductible is met
Rehabilitation services:		
Office *Coverage for rehabilitative and habilitative physical therapy, occupational therapy, speech therapy, and manipulative treatment is limited to 50 visits combined per benefit period.*	$25 copay per visit deductible does not apply	30% coinsurance after deductible is met
Outpatient Hospital *Coverage for rehabilitative and habilitative physical therapy, occupational therapy, speech therapy, and manipulative treatment is limited to 50 visits combined per benefit period.*	$25 copay per visit deductible does not apply	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Cardiac rehabilitation Office *Coverage is limited to 36 visits per benefit period.* Outpatient Hospital *Coverage is limited to 36 visits per benefit period.*	No charge 10% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage is limited to 120 days per benefit period.*	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Hospice	No charge	30% coinsurance after deductible is met
Durable Medical Equipment	No charge	30% coinsurance after deductible is met
Prosthetic Devices	No charge	30% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out of Pocket	Combined with medical	Combined with medical
Prescription Drug Coverage *National with R90* *National Drug List* *This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs.*		
Tier 1 - Typically Generic *30 day supply (retail pharmacy). 90 day supply (home delivery).* *$1,000 maximum per person per benefit period.*	$10 copay per prescription, deductible does not apply (retail and home delivery)	20% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).* *$1,000 maximum per person per benefit period.*	$35 copay per prescription, deductible does not apply (retail and home delivery)	20% coinsurance, deductible does not apply (retail) and Not

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
		covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).* *$1,000 maximum per person per benefit period.*	$45 copay per prescription, deductible does not apply (retail and home delivery)	20% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Notes:

- Your copays, coinsurance and deductible count toward your out of pocket amount.
- 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.

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 (800) 922-6621

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 (800) 922-6621 .

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՝ (800) 922-6621:

Chinese(中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(800) 922-6621。

Farsi (فارسي) : در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (800) 922-6621 تماس بگیرید.

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (800) 922-6621.

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 (800) 922-6621.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (800) 922-6621.

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Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'idiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí łą' bich'į' hadeesdzih ninízingo kojį' hodíilnih (800) 922-6621.

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: (800) 922-6621.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (800) 922-6621 ਤੇ ਕਾਲ ਕਰੋ।

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. (800) 922-6621.

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