

Your summary of benefits



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	\$0 person / \$0 family	\$300 person / \$750 family
Out-of-Pocket Limit	\$6,600 person / \$13,200 family	\$1,100 person / \$2,750 family
<p>The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to the per person out-of-pocket maximum; in addition, amounts for all covered family members apply to the family out-of-pocket maximum. No one member will pay more than the per person out-of-pocket maximum.</p> <p>Your copays, coinsurance and deductible count toward your out of pocket amount(s).</p> <p>In-network and out-of-network out-of-pocket maximum amounts are separate and do not accumulate toward each other.</p>		
Preventive Care / Screening / Immunization	No charge	20% coinsurance after deductible is met
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	20% coinsurance after deductible is met
<p><u>Virtual Care (Telemedicine / Telehealth Visits)</u></p> <p>Virtual Visits - Online visits with Doctors who also provide services in person</p>		
Primary Care (PCP)	\$25 copay per visit	20% coinsurance after deductible is met
Mental Health and Substance Abuse care	\$25 copay per visit	20% coinsurance after deductible is met
Specialist	\$25 copay per visit	20% coinsurance after deductible is met

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

CT/LG/NORWICH:TOWN AND BOARD OF EDUCATION (Non Med Wrap): Anthem Century Preferred PPO PS CSV/5HMP/07-01-2022

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Medical Chats and Virtual (Video) Visits for Primary Care from our Online Provider K Health, through its affiliated Provider groups	No charge	
Virtual Visits from Online Provider LiveHealth Online via www.livehealthonline.com ; our mobile app, website or Anthem-enabled device Primary Care (PCP) and Mental Health and Substance Abuse Specialist Care	\$25 copay per visit \$25 copay per visit	
<u>Visits in an Office</u> Primary Care (PCP) Specialist Care	\$25 copay per visit \$25 copay per visit	20% coinsurance after deductible is met 20% coinsurance after deductible is met
<u>Other Practitioner Visits</u> Routine Maternity Care (Prenatal and Postnatal) Retail Health Clinic 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> Acupuncture	No charge \$25 copay per visit \$25 copay per visit No charge	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met
<u>Other Services in an Office</u> Allergy Testing Chemo/Radiation Therapy Dialysis/Hemodialysis Prescription Drugs <i>Dispensed in the office</i>	\$25 copay per visit [†] No charge No charge No charge	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met 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
Surgery	No charge	20% coinsurance after deductible is met
<u>Diagnostic Services</u> Lab Office Freestanding/Site of Service Lab Outpatient Hospital	No charge No charge No charge	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met
X-Ray Office Freestanding/Site of Service Radiology Center Outpatient Hospital	No charge No charge No charge	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met
Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i> Office Freestanding/Site of Service Radiology Center Outpatient Hospital	No charge No charge No charge	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met
<u>Emergency and Urgent Care</u> Urgent Care Emergency Room Facility Services <i>Copay waived if admitted.</i> Emergency Room Doctor and Other Services Ambulance	\$75 copay per visit \$150 copay per visit No charge No charge	20% coinsurance after deductible is met Covered as In-Network Covered as In-Network Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><u>Outpatient Mental Health and Substance Abuse</u></p> <p>Doctor Office Visit</p> <p>Facility Visit</p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>\$25 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><u>Outpatient Surgery</u></p> <p>Facility Fees</p> <p>Hospital</p> <p>Freestanding Surgical Center</p> <p>Doctor and Other Services</p> <p>Hospital</p> <p>Freestanding Surgical Center</p>	<p>\$250 copay per visit</p> <p>\$250 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><u>Hospital (Including Maternity, Mental Health and Substance Abuse)</u></p> <p>Facility Fees</p> <p>Doctor and other services</p>	<p>\$250 copay per admission</p> <p>No charge</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>
<p><u>Recovery & Rehabilitation</u></p> <p>Home Health Care</p> <p><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>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Rehabilitation services <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>Office</p> <p>Outpatient Hospital</p>	<p>\$25 copay per visit</p> <p>\$25 copay per visit</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>
<p>Cardiac rehabilitation <i>Coverage is limited to 36 visits 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>Skilled Nursing Care (facility) <i>Coverage is limited to 120 days per benefit period.</i></p>	<p>\$250 copay per admission</p>	<p>20% coinsurance after deductible is met</p>
<p>Inpatient Hospice</p>	<p>No charge</p>	<p>20% coinsurance after deductible is met</p>
<p>Durable Medical Equipment</p>	<p>No charge</p>	<p>20% coinsurance after deductible is met</p>
<p>Prosthetic Devices <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i></p>	<p>No charge</p>	<p>20% coinsurance after deductible is met</p>

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<p>Pharmacy Deductible</p>	<p>Not applicable</p>	<p>Not applicable</p>
<p>Pharmacy Out-of-Pocket Limit</p>	<p>Not applicable</p>	<p>Not applicable</p>

Prescription Drug Coverage Cost shares for drugs included on the National drug list appear below. Your plan uses the Base Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<p>Home Delivery Pharmacy Maintenance medication are available through Home Delivery Pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.</p>		
<p>Tier 1 - Typically Generic Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery). \$1,500 maximum per person per benefit period.</p>	<p>\$15 copay per prescription, deductible does not apply (retail and home delivery)</p>	<p>20% coinsurance, deductible does not apply (retail) and Not covered (home delivery)</p>
<p>Tier 2 – Typically Preferred Brand Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery). \$1,500 maximum per person per benefit period.</p>	<p>\$30 copay per prescription, deductible does not apply (retail and home delivery)</p>	<p>20% coinsurance, deductible does not apply (retail) and Not covered (home delivery)</p>
<p>Tier 3 - Typically Non-Preferred Brand/Specialty Drugs Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery). Per 30 day (specialty pharmacy). \$1,500 maximum per person per benefit period.</p>	<p>\$40 copay per prescription, deductible does not apply (retail and home delivery)</p>	<p>20% coinsurance, deductible does not apply (retail) and Not covered (home delivery)</p>

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><i>This is a brief outline of your vision coverage. Adult and children's vision services count towards your out of pocket limit.</i></p>		
<p>Child Vision exam Limited to 1 exam every 2 benefit periods.</p>	<p>No charge</p>	<p>20% coinsurance after deductible is met</p>
<p>Adult Vision exam Limited to 1 exam every 2 benefit periods.</p>	<p>No charge</p>	<p>20% coinsurance after deductible is met</p>

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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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.

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 (888) 224-4896.

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Language Access Services:

Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'idiikidgo ná bohónéedzǎ dóó bee ahóót'i' t'áá ni nizaad k'ehǫ́ bee nił hodoonih t'áadoo bǫ́ǫ́h ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih ninizingo kojǫ́' hodíílnih (888) 224-4896.

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.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (888) 224-4896 ਤੇ ਕਾਲ ਕਰੋ।

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