

# Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Century Preferred PPO PS CSV \$25/\$200/\$100/\$150 Rx \$10/\$25/\$40

Your Network: Century Preferred

City \$25 Plan

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
<b>Primary Care, and medical services for urgent/acute care</b>	No charge
<b>Mental Health &amp; Substance Use Disorder Services</b>	No charge
<b>Specialist care</b>	\$35 copay per visit

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b>	\$0 person / \$0 employee +1 / \$0 family	\$400 person / \$800 employee +1 / \$1,200 family
<b>Overall Out-of-Pocket Limit</b>	\$6,350 person / \$12,700 employee +1 / \$12,700 family	\$1,900 person / \$3,800 employee +1 / \$5,750 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 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).*

<b>Primary Care (PCP)</b> <i>virtual and office</i>	\$25 copay per visit	20% coinsurance after deductible is met
<b>Mental Health and Substance Use Disorder Services</b> <i>virtual and office</i>	No charge	20% coinsurance after deductible is met
<b>Specialist Care</b> <i>virtual and office</i>	\$35 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><b><u>Other Practitioner Visits</u></b></p> <p><b>Routine Maternity Care</b> (Prenatal and Postnatal)</p> <p><b>Retail Health Clinic</b> <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i></p> <p><b>Manipulation Therapy</b> <i>Coverage for rehabilitative and habilitative physical therapy, occupational therapy, speech therapy, cognitive therapy and manipulative treatment is limited to 50 visits combined per benefit period.</i></p> <p><b>Acupuncture</b></p>	<p>No charge</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>20% coinsurance after deductible is met</p>
<p><b><u>Other Services in an Office</u></b></p> <p><b>Allergy Testing</b></p> <p><b>Prescription Drugs</b> <i>Dispensed in the office</i></p> <p><b>Surgery</b></p>	<p>\$25 copay per visit<sup>†</sup></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><b>Preventive care / screenings / immunizations</b></p>	<p>No charge</p>	<p>20% coinsurance after deductible is met</p>
<p><b>Preventive Care for Chronic Conditions</b> <i>per IRS guidelines</i></p>	<p>No charge</p>	<p>20% coinsurance after deductible is met</p>
<p><b><u>Diagnostic Services</u></b></p> <p><b>Lab</b></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>
<p><b>X-Ray</b></p> <p>Office</p> <p>Freestanding/Site of Service Radiology Center</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>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	No charge	20% coinsurance after deductible is met
<b>Advanced Diagnostic Imaging</b> <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><b>Emergency and Urgent Care</b></u>  <b>Urgent Care</b> <i>includes doctor services. Additional charges may apply depending on the care provided.</i>  <b>Emergency Room Facility Services</b> <i>Your copay will be waived if admitted.</i>  <b>Emergency Room Doctor and Other Services</b>  <b>Ambulance</b> <i>Authorized Non-Network non-emergency ambulance services are limited to an Anthem maximum payment of \$50,000 per trip.</i>	\$25 copay per visit  \$100 copay per visit  No charge  No charge	Covered as In-Network  Covered as In-Network  Covered as In-Network  Covered as In-Network
<b>Outpatient Mental Health and Substance Use Disorder Services at a Facility</b>  Facility Fees  Doctor Services	No charge  No charge	20% coinsurance after deductible is met  20% coinsurance after deductible is met
<u><b>Outpatient Surgery</b></u>  <b>Facility Fees</b> Hospital  Ambulatory Surgical Center/Site of Service Provider  <b>Physician and other services</b> <i>including surgeon fees</i> Hospital  Ambulatory Surgical Center/Site of Service Provider	\$150 copay per visit  \$150 copay per visit  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
<p><b><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u></b>  <i>If readmitted within 60 days for the same condition, no additional facility copay is required. If transferred between facilities, only one copay will apply.</i></p> <p><b>Facility Fees</b></p> <p><b>Physician and other services</b> <i>including surgeon fees</i></p>	<p>\$200 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><b>Home Health Care</b>  <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><b>Rehabilitation and Habilitation services</b> <i>including physical, occupational, speech, and cognitive therapies.</i>  <i>Coverage for physical, occupational, speech, and cognitive 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><b>Pulmonary rehabilitation</b> <i>office and outpatient hospital</i></p>	<p>No charge</p>	<p>20% coinsurance after deductible is met</p>
<p><b>Cardiac rehabilitation</b> <i>office and outpatient hospital</i>  <i>Coverage is limited to 36 visits per benefit period.</i></p>	<p>No charge</p>	<p>20% coinsurance after deductible is met</p>
<p><b>Dialysis/Hemodialysis</b> <i>office and outpatient hospital</i></p>	<p>No charge</p>	<p>20% coinsurance after deductible is met</p>
<p><b>Chemo/Radiation Therapy</b> <i>office and outpatient hospital</i></p>	<p>No charge</p>	<p>20% coinsurance after deductible is met</p>
<p><b>Skilled Nursing Care (facility)</b>  <i>Coverage is limited to 120 days per benefit period.</i></p>	<p>No charge</p>	<p>20% coinsurance after deductible is met</p>
<p><b>Inpatient Hospice</b></p>	<p>No charge</p>	<p>20% coinsurance after deductible is met</p>
<p><b>Durable Medical Equipment</b></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
<b>Prosthetic Devices</b>	No charge	20% coinsurance after deductible is met
<b>Hearing Aids</b> <i>Coverage is limited to 1 item per ear every 2 benefit periods.</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
<b>Pharmacy Deductible</b>	Not applicable	Not applicable
<b>Pharmacy Out-of-Pocket Limit</b>	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
<b>Prescription Drug Coverage</b> <b>Network: <i>Base Network</i></b> <b>Drug List: <i>National</i></b> <i>If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.</i>		
<b>Day Supply Limits:</b> <b>Retail Pharmacy</b> <i>30 day supply (cost shares noted below)</i> <b>Retail 90 Pharmacy</b> <i>90 day supply (2 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).</i> <b>Home Delivery Pharmacy</b> <i>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.</i> <b>Specialty Pharmacy</b> <i>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.</i>		
<b>Tier 1 - Typically Generic</b>	\$10 copay per prescription (retail) and \$20 copay per prescription (home delivery)	20% coinsurance (retail) and Not covered (home delivery)
<b>Tier 2 – Typically Preferred Brand</b>	\$25 copay per prescription (retail) and \$50 copay per prescription (home delivery)	20% coinsurance (retail) and Not covered (home delivery)
<b>Tier 3 - Typically Non-Preferred Brand/Specialty Drugs</b>	\$40 copay per prescription (retail) and \$80 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 and children's vision services count towards your out-of-pocket limit.</i>		
<b>Child Vision exam</b> <i>Limited to 1 exam every 2 benefit periods.</i>	No charge	20% coinsurance after deductible is met
<b>Adult Vision exam</b> <i>Limited to 1 exam every 2 benefit periods.</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.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
- ‡ You will pay the PCP's office visit copay when services are provided in their 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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Questions: (833) 899-7070 or visit us at [www.anthem.com](http://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 (833) 899-7070

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 (833) 899-7070

**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՝ (833) 899-7070:

**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(833) 899-7070。

**Farsi (فارسی):** 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 (833) 899-7070 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 (833) 899-7070.

**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 (833) 899-7070.

**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 (833) 899-7070.

**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、(833) 899-7070 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(833) 899-7070로 문의하십시오.

**Navajo (Diné):** Díí naaltsoos biká'ígíí lahgo bina'ídiłkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj bee níl hodoonih t'áadoo báąh ilinígóó. Ata' halne'ígíí la' bich'í' hadeesdzih ninizingo koǫ́' hodiilnih (833) 899-7070.

## Language Access Services:

**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: (833) 899-7070.

**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 ਦੁਬਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (833) 899-7070 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. (833) 899-7070.

**Spanish (Español):** Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (833) 899-7070.

**Tagalog (Tagalog):** Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (833) 899-7070.

**Vietnamese (Tiếng Việt):** Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (833) 899-7070.

### 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>.