Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Century Preferred PPO PS CSV $25/$200/$25/$200 Rx $5/$25/$40

Your Network: Century Preferred

Personalized for: RSD #14 - Teachers and Retired Teachers

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	$25 copay per visit

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$0 person / $0 employee +1 / $0 family	$200 person / $400 employee +1 / $500 family
Overall Out-of-Pocket Limit	$6,600 person / $13,200 employee +1 / $13,200 family	$400 person / $800 employee +1 / $1,000 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).*		
Primary Care (PCP) *virtual and office*	$25 copay per visit	20% coinsurance after deductible is met
Mental Health and Substance Use Disorder Services *virtual and office*	No charge	20% coinsurance after deductible is met
Specialist Care *virtual and office*	$25 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
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	No charge	20% coinsurance after deductible is met
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$25 copay per visit	20% coinsurance after deductible is met
Manipulation Therapy *Coverage for rehabilitative and habilitative physical therapy, occupational therapy, speech therapy, and manipulative treatment is limited to 50 visits combined per benefit period.*	No charge	20% coinsurance after deductible is met
Acupuncture	No charge	20% coinsurance after deductible is met
Other Services in an Office		
Allergy Testing	$25 copay per visit‡	20% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	No charge	20% coinsurance after deductible is met
Surgery	No charge	20% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	20% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	20% coinsurance after deductible is met
Diagnostic Services **Lab**		
Office	No charge	20% coinsurance after deductible is met
Freestanding/Site of Service Lab	No charge	20% coinsurance after deductible is met
Outpatient Hospital	No charge	20% coinsurance after deductible is met
X-Ray		
Office	No charge	20% coinsurance after deductible is met
Freestanding/Site of Service Radiology Center	No charge	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
Outpatient Hospital	No charge	20% coinsurance after deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	No charge	20% coinsurance after deductible is met
Freestanding/Site of Service Radiology Center	No charge	20% coinsurance after deductible is met
Outpatient Hospital	No charge	20% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	$25 copay per visit	Covered as In-Network
Emergency Room Facility Services *Your copay will be waived if admitted.*	$25 copay per visit	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	Covered as In-Network
Ambulance *Authorized Non-Network non-emergency ambulance services are limited to an Anthem maximum payment of $50,000 per trip.*	No charge	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	No charge	20% coinsurance after deductible is met
Doctor Services	No charge	20% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	$200 copay per visit	20% coinsurance after deductible is met
Ambulatory Surgical Center/Site of Service Provider	$200 copay per visit	20% coinsurance after deductible is met
Physician and other services *including surgeon fees*		
Hospital	No charge	20% coinsurance after deductible is met
Ambulatory Surgical Center/Site of Service Provider	No charge	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
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services) *If readmitted within 60 days for the same condition, no additional facility copay is required. If transferred between facilities, only one copay will apply.*		
Facility Fees	$200 copay per admission	20% coinsurance after deductible is met
Physician and other services *including surgeon fees*	No charge	20% coinsurance after deductible is met
Home Health Care *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.*	No charge	20% coinsurance after a $50 deductible is met
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for physical, occupational and speech therapies and manipulative treatment is limited to 50 visits combined per benefit period.*		
Office	No charge	20% coinsurance after deductible is met
Outpatient Hospital	No charge	20% coinsurance after deductible is met
Pulmonary rehabilitation *office and outpatient hospital*	No charge	20% coinsurance after deductible is met
Cardiac rehabilitation *office and outpatient hospital* *Coverage is limited to 36 visits per benefit period.*	No charge	20% coinsurance after deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	No charge	20% coinsurance after deductible is met
Chemo/Radiation Therapy *office and outpatient hospital*	No charge	20% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage is limited to 120 days per benefit period.*	$200 copay per admission	20% coinsurance after deductible is met
Inpatient Hospice	No charge	20% coinsurance after deductible is met
Durable Medical Equipment	No charge	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
Prosthetic Devices	No charge	20% coinsurance after deductible is met
Hearing Aids *Coverage is limited to 1 item per ear every 2 benefit periods.*	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:** ***Base Network*** **Drug List:** ***Essential***		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).* **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** *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.*		
Tier 1 - Typically Generic	$5 copay per prescription (retail) and $10 copay per prescription (home delivery)	20% coinsurance (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand	$25 copay per prescription (retail) and $50 copay per prescription (home delivery)	20% coinsurance (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand/Specialty Drugs	$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
This is a brief outline of your vision coverage. Adult and children's vision services count towards your out-of-pocket limit.		
Child Vision exam *Limited to 1 exam per benefit period.*	No charge	20% coinsurance after deductible is met
Adult Vision exam *Limited to 1 exam per benefit period.*	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

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(TTY/TDD: 711)

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