Your summary of benefits

Anthem

Anthem® Blue Cross and Blue Shield

Your Plan: Naugatuck, Borough and Board of Education: Anthem Century Preferred PPO HSA

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 after deductible is met
Mental Health & Substance Use Disorder Services	No charge
Specialist care	No charge after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	$2,250 person / $4,500 family	$2,250 person / $4,500 family
Overall Out-of-Pocket Limit	$3,250 person / $3,250 person on a family/ $6,500 family	$5,000 person / $5,000 person on a family/ $10,000 family
The family deductible is non-embedded, meaning when more than a single person is enrolled, the per person deductible does not apply and the family deductible must be met by any one person or collection of persons. The out-of-pocket limit is non-embedded, meaning each covered person is capped at his or her per person out-of-pocket limit. The In-Network and Out-of-Network deductibles are combined and accumulate toward each other. The In-Network and Out-of-Network out-of-pocket limit amounts accumulate toward each other.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Primary Care (PCP) and Mental Health and Substance Use Disorder Services *virtual and office*	No charge after deductible is met	30% coinsurance after deductible is met
Specialist Care *virtual and office*	No charge after deductible is met	30% coinsurance after deductible is met
Other Practitioner Visits **Maternity Doctor services**		
Prenatal and Postnatal care	No charge	30% coinsurance after deductible is met
Delivery	No charge after deductible is met	30% coinsurance after deductible is met
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	No charge 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 an Out-of-Network Provider
Manipulation Therapy	No charge after deductible is met	30% coinsurance after deductible is met
Acupuncture	No charge after deductible is met	30% coinsurance after deductible is met
Other Services in an Office		
Allergy Testing	No charge after deductible is met	30% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	No charge after deductible is met	30% coinsurance after deductible is met
Surgery	No charge after deductible is met	30% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	30% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	30% coinsurance after deductible is met
Diagnostic Services		
Lab		
Office	No charge after deductible is met	30% coinsurance after deductible is met
Freestanding/Site of Service Lab	No charge after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	No charge after deductible is met	30% coinsurance after deductible is met
X-Ray		
Office	No charge after deductible is met	30% coinsurance after deductible is met
Freestanding/Site of Service Radiology Center	No charge after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	No charge after deductible is met	30% coinsurance after deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans Member cost share will not exceed $375 copayment maximum for MRI, MRA, CAT, CTA, PET, and SPECT scans, per member per benefit period.*		
Office	No charge after deductible is met	30% coinsurance after deductible is met
Freestanding/Site of Service Radiology Center	No charge after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	$75 copay per visit and No charge after deductible is met	30% coinsurance after deductible is met
Emergency and Urgent Care		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Urgent Care	No charge after deductible is met	30% coinsurance after deductible is met
Emergency Room Facility Services	No charge after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	No charge after deductible is met	Covered as In-Network
Ambulance	No charge after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	No charge after deductible is met	30% coinsurance after deductible is met
Doctor Services	No charge after deductible is met	30% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	No charge after deductible is met	30% coinsurance after deductible is met
Ambulatory Surgical Center/Site of Service Provider	No charge after deductible is met	30% coinsurance after deductible is met
Physician and other services *including surgeon fees*		
Hospital	No charge after deductible is met	30% coinsurance after deductible is met
Ambulatory Surgical Center/Site of Service Provider	No charge after deductible is met	30% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)		
Facility Fees	No charge after deductible is met	30% coinsurance after deductible is met
Physician and other services *including surgeon fees*	No charge after deductible is met	30% coinsurance after deductible is met
Home Health Care *Coverage is limited to 200 visits per benefit period.*	No charge after deductible is met	25% coinsurance after deductible is met
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.*		
Office	No charge after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	No charge 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 an Out-of-Network Provider
Pulmonary rehabilitation *office and outpatient hospital*	No charge after deductible is met	30% coinsurance after deductible is met
Cardiac rehabilitation *office and outpatient hospital*	No charge after deductible is met	30% coinsurance after deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	No charge after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy *office and outpatient hospital*	No charge after deductible is met	30% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage is limited to 220 days per benefit period.*	No charge after deductible is met	30% coinsurance after deductible is met
Inpatient Hospice	No charge after deductible is met	30% coinsurance after deductible is met
Durable Medical Equipment	No charge after deductible is met	30% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 unit after cancer treatment per benefit period.*	No charge after deductible is met	30% coinsurance after deductible is met
Hearing Aids	No charge after deductible is met	30% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with Out-of-Network medical deductible
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Out-of-Network medical out-of-pocket limit
Prescription Drug Coverage **Network:** ***Base Network*** **Drug List:** ***National*** *If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.* **Preventive Drugs** *No deductible, copayment or coinsurance applies to prescription drugs on the Preventive RX Plus drug list when you use an In-Network Pharmacy.* **Prior Authorization Requirement**		
Day Supply Limits: **Retail Pharmacy** *90 day supply (cost shares noted below)* **Home Delivery Pharmacy** *100 day supply (maximum cost shares noted below). Maintenance medications are available through our 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.*		

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Specialty Pharmacy *90 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 after deductible is met (retail) and $10 copay per prescription after deductible is met (home delivery)	30% coinsurance after deductible is met (retail and home delivery)
Tier 2 - Typically Preferred Brand	$25 copay per prescription after deductible is met (retail) and $50 copay per prescription after deductible is met (home delivery)	30% coinsurance after deductible is met (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand/Specialty Drugs	$40 copay per prescription after deductible is met (retail) and $80 copay per prescription after deductible is met (home delivery)	30% coinsurance after deductible is met (retail and home delivery)

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.
- The representations of benefits in this document are subject to CT Department of Insurance (CT DOI) approval and are subject to change.

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.

Questions: (833) 899-7070 or visit us at www.anthem.com

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’re here for you – in many languages

law requires us to include a message in all of these different languages. Curious what they say? Here’s the English version: “You e the right to get help in your language for free. Just call the Member Services number on your ID card. Visually impaired? You can ask for other formats of this document.

anish
e el derecho de obtener ayuda en su idioma de forma gratuita. Solo llame al número de Servicios para Miembros figura en su tarjeta de identificación ¿Tiene alguna ciencia visual? También puede solicitar este umento en otros formatos.

nese
有權免費獲得使用您的語言提供的協助。只需撥打印於您 D 卡上的會員服務部電話號碼即可。視力障礙？您也可索取本文件的其他格式。

tnamese
ý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, n phí. Quý vị chỉ cần gọi đến số điện thoại của Ban n vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm Quý vị cũng có thể yêu cầu các định dạng khác của iệu này.

rean
는 귀하의 언어로 된 도움을 무료로 받을 권리가 습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 하십시오. 시각 장애인이신가요? 다른 형식으로 이 문서를 요청하실 수 있습니다.

alog
y karapatan kang makakuha ng tulong na nasa iyong a nang libre. Tawagan lang ang numero ng Member vices na nasa iyong ID card. May kapansanan sa ingin? Maaari ka ring humingi ng iba pang mga mat ng dokumentong ito.

ssian
ас есть право на бесплатное получение помощи вашем родном языке. Просто позвоните в отдел луживания участников по номеру, указанному на шей идентификационной карте. У вас проблемы рением? Вы также можете запросить этот документ угих форматах.

nch Creole
gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo vis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? ka mande tou pou lòt fòma nan dokiman sa a.

bic
لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك م
فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من
ضعف البصر؟ يمكنك أيضًا طلب تنسيقات أخرى لهذه الوثيقة.

nch
s avez le droit d’obtenir de l’aide dans votre langue tuitement. Appelez simplement le numéro du Services mbres figurant sur votre carte d’identité. Vous êtes une sonne malvoyante ? Vous pouvez également demander ccéder à ce document dans d’autres formats.

sian
شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره
خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال
بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

Armenian
Ձեր իրավունքն է ձեր լեզվով անվճար օգնություն ստանալ: Պարզապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցո՞ղ եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

Japanese
あなたにはあなたの言語で無料で支援を受ける権利があります。ID カードに記載されている会員サービス番号にお電話ください」視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

Italian
Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

German
Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen Formaten anfordern.

Polish
Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

Pennsylvania Dutch
Du hoscht’s Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kannscht des do Schreiwes in en differnter Weg griege so as du’s besser sehne kannscht.

TTY/TTD:711

It’s important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don’t discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn’t English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or directly to 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. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf