Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Plan: Capital Area Health: Anthem Century Preferred PPO

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	$200 person / $600 family
Out-of-Pocket Limit	$6,600 person / $13,200 family	$1,200 person / $1,600 family
The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per person 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 per person deductible or per person out-of-pocket maximum. Your copays, coinsurance and deductible count toward your out of pocket amount(s). In-network and out-of-network out-of-pocket maximum amounts are separate and do not accumulate toward each other.		
Preventive Care / Screening / Immunization	No charge	20% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	20% coinsurance after deductible is met
Virtual Care (Telemedicine / Telehealth Visits) **Virtual Visits - Online visits with Doctors who also provide services in person**		
Primary Care (PCP)	$15 copay per visit	20% coinsurance after deductible is met
Mental Health and Substance Abuse care	No charge	20% coinsurance after deductible is met
Specialist	$20 copay per visit	20% coinsurance after deductible is met
Medical Chats and Virtual (Video) Visits for Primary Care from our Online Provider K Health, through its affiliated Provider groups	No charge	

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
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	No charge	
Specialist Care	$20 copay per visit	
Visits in an Office		
Primary Care (PCP)	$15 copay per visit	20% coinsurance after deductible is met
Specialist Care	$20 copay per visit	20% coinsurance after deductible is met
Other Practitioner Visits		
Routine Maternity Care Prenatal *All office visit copayments count towards the same 1 visit limit.*	$20 copay per visit for the first 1 visit	20% coinsurance after deductible is met
Postnatal	No charge	20% coinsurance after deductible is met
Retail Health Clinic	$15 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 *Coverage is limited to 50 visits per benefit period.*	No charge	20% coinsurance after deductible is met
Other Services in an Office		
Allergy Testing *When Allergy injections are billed separately by network providers, the member is responsible for No charge. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$20 copay per visit	20% coinsurance after deductible is met
Chemo/Radiation Therapy	No charge	20% coinsurance after deductible is met
Dialysis/Hemodialysis	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
Prescription Drugs *Dispensed in the office*	No charge	20% coinsurance after deductible is met
Surgery	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
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	$25 copay per visit	Not covered
Emergency Room Facility Services *Copay waived if admitted.*	$50 copay per visit	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	Covered as In-Network
Ambulance	No charge	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Mental Health and Substance Abuse		
Doctor Office Visit	No charge	20% coinsurance after deductible is met
Facility Visit		
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	No charge	20% coinsurance after deductible is met
Freestanding Surgical Center	No charge	20% coinsurance after deductible is met
Doctor and Other Services		
Hospital	No charge	20% coinsurance after deductible is met
Freestanding Surgical Center	No charge	20% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	No charge	20% coinsurance after deductible is met
Doctor and other services	No charge	20% coinsurance after deductible is met
Recovery & Rehabilitation		
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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Rehabilitation services *Coverage for rehabilitative and habilitative physical therapy, occupational therapy, speech therapy, 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
Cardiac rehabilitation *Coverage is limited to 36 visits per episode.*		
Office	No charge	20% coinsurance after deductible is met
Outpatient Hospital	No charge	20% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage is limited to 120 days per benefit period.*	No charge	20% coinsurance after deductible is met
Inpatient Hospice *Coverage is limited to 60 days per benefit period.*	$200 copay per admission	20% coinsurance after deductible is met
Durable Medical Equipment	No charge	20% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	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 *Cost shares for drugs included on the National drug list appear below. Your plan uses the Base Network.*		

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Home Delivery Pharmacy *Maintenance medication are available through IngenioRx 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.*		
Tier 1 - Typically Generic *Per 34 day supply (retail pharmacy). Per 100 day supply (home delivery).*	$10 copay per prescription, deductible does not apply (retail) and $0 copay per prescription, deductible does not apply (home delivery)	20% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *Per 34 day supply (retail pharmacy). Per 100 day supply (home delivery).*	$20 copay per prescription, deductible does not apply (retail) and $0 copay per prescription, deductible does not apply (home delivery)	20% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand/Specialty Drugs *Per 34 day supply (retail pharmacy). Per 100 day supply (home delivery). Per 34 day (specialty pharmacy).*	$20 copay per prescription, deductible does not apply (retail) and $0 copay per prescription, deductible does not apply (home delivery)	20% coinsurance, deductible does not apply (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.		
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.

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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(TTY/TDD: 711)

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