

Capital Area Health: Anthem Century Preferred PPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, <https://eoc.anthem.com/eocdps/aso>. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call (888) 224-4896 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$0/person or \$0/family for In- <a href="#">Network Providers</a> . \$200/person or \$600/family for Non- <a href="#">Network Providers</a> .	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. Primary Care. <a href="#">Specialist Visit</a> . <a href="#">Preventive Care</a> . Certain <a href="#">Prescription Drugs</a> . For more information see below.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes. \$50/person for Home Health care Non- <a href="#">Network Providers</a> . There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$6,600/person or \$13,200/family for In- <a href="#">Network Providers</a> . \$1,200/person or \$1,600/family for Non- <a href="#">Network Providers</a> .	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, health care this <a href="#">plan</a> doesn't cover, and Non- <a href="#">Network Transplants</a> .	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.anthem.com/find-care/?alphaprefix=AZL">www.anthem.com/find-care/?alphaprefix=AZL</a> or call (888) 224-4896 for a list of <a href="#">network providers</a> . Costs may vary by site of service and how	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.

	the <a href="#">provider</a> bills.	
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	Office \$15/visit Virtual No charge	20% <a href="#">coinsurance</a>	Virtual visits (Telehealth) benefits available.
	<a href="#">Specialist</a> visit	Office \$20/visit Virtual No charge	20% <a href="#">coinsurance</a>	Virtual visits (Telehealth) benefits available.
	<a href="#">Preventive care</a> / <a href="#">screening</a> / immunization	No charge	20% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	20% <a href="#">coinsurance</a>	-----none-----
	Imaging (CT/PET scans, MRIs)	No charge	20% <a href="#">coinsurance</a>	-----none-----
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a>	Typically Generic (Tier 1)	\$10/prescription (retail) and \$0/prescription (home delivery)	20% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply (retail) and Not covered (home delivery)	For more information, refer to "National Drug List" at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a> *See Prescription Drug section
	Typically Preferred Brand (Tier 2)	\$20/prescription (retail) and \$0/prescription (home delivery)	20% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply (retail) and Not covered (home delivery)	
	Typically Non-Preferred Brand and Generic drugs (Tier 3)	\$20/prescription (retail) and \$0/prescription (home delivery)	20% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply (retail) and Not covered (home delivery)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	20% <a href="#">coinsurance</a>	-----none-----
	Physician/surgeon fees	No charge	20% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Emergency room care</a>	\$50/visit	Covered as In- <a href="#">Network</a>	<a href="#">Copayment</a> waived if admitted.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://eoc.anthem.com/eocdps/aso>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need immediate medical attention	<a href="#">Emergency medical transportation</a>	No charge	Covered as In- <a href="#">Network</a>	Non-emergency Non- <a href="#">Network</a> Ambulance Services are limited to \$50,000 per trip.
	<a href="#">Urgent care</a>	\$25/visit	Not covered	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% <a href="#">coinsurance</a>	60 days/benefit period for Inpatient rehabilitation.
	Physician/surgeon fees	No charge	20% <a href="#">coinsurance</a>	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit No charge Other Outpatient No charge	Office Visit 20% <a href="#">coinsurance</a> Other Outpatient 20% <a href="#">coinsurance</a>	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient -----none-----
	Inpatient services	No charge	20% <a href="#">coinsurance</a>	-----none-----
If you are pregnant	Office visits	\$20/visit for the first 1 visit	20% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . No charge for Postnatal In- <a href="#">Network Providers</a> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	20% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	No charge	20% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	20% <a href="#">coinsurance</a> , <a href="#">Home Health Care deductible</a> applies	200 visits/benefit period.
	<a href="#">Rehabilitation services</a>	No charge	20% <a href="#">coinsurance</a>	*See Therapy Services section.
	<a href="#">Habilitation services</a>	No charge	20% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	No charge	20% <a href="#">coinsurance</a>	120 days/benefit period for skilled nursing services.
	<a href="#">Durable medical equipment</a>	No charge	20% <a href="#">coinsurance</a>	*See <a href="#">Durable Medical Equipment</a> Section
	<a href="#">Hospice services</a>	\$200/admission	20% <a href="#">coinsurance</a>	60 days/benefit period.
	Children's glasses	Not covered	Not covered	
Children's dental check-up	Not covered	Not covered	-----none-----	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://eoc.anthem.com/eocdps/aso>.

## Excluded Services & Other Covered Services:

### Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Children’s dental check-up
- Glasses for a child
- Weight loss programs
- Cosmetic surgery
- Long-term care
- Dental care
- Routine foot care unless you have been diagnosed with diabetes

### Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your [plan](#) document.)

- Acupuncture 50 visits/benefit period
- Hearing aids 1 item(s)/ear every 2 years
- Private-duty nursing \$15,000 maximum/benefit period Facility Setting only
- Bariatric surgery
- Infertility treatment (In-[Network](#))
- Routine eye care 1 exam/benefit period
- Chiropractic care 50 visits/benefit period combined with all other therapies
- Most coverage provided outside the United States. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Connecticut Department of Insurance, 153 Market Street, 7th Floor, Hartford, CT 06103, (860) 297-3000, (800) 203-3447, Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or contact Anthem at the number on the back of your ID card. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact:

ATTN: Grievances and Appeals, P.O. Box 1038, North Haven, CT 06473-4201

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

Connecticut Office of Healthcare Advocate, P.O. Box 1543, Hartford, CT 06144, (866) 466-4446, [www.ct.gov/oha](http://www.ct.gov/oha), [healthcare.advocate@ct.gov](mailto:healthcare.advocate@ct.gov)

### Does this plan provide Minimum Essential Coverage? Yes/No.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet the Minimum Value Standards? Yes/No.**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$20	■ <a href="#">Specialist copayment</a>	\$20	■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	0%	■ Hospital (facility) <a href="#">coinsurance</a>	0%	■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	0%	■ Other <a href="#">coinsurance</a>	0%	■ Other <a href="#">coinsurance</a>	0%
<p>This EXAMPLE event includes services like:</p> <p><a href="#">Specialist</a> office visits (<i>prenatal care</i>)            Childbirth/Delivery Professional Services            Childbirth/Delivery Facility Services  <a href="#">Diagnostic tests</a> (<i>ultrasounds and blood work</i>)  <a href="#">Specialist</a> visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like:</p> <p><a href="#">Primary care physician</a> office visits (<i>including disease education</i>)  <a href="#">Diagnostic tests</a> (<i>blood work</i>)  <a href="#">Prescription drugs</a>  <a href="#">Durable medical equipment</a> (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like:</p> <p><a href="#">Emergency room care</a> (<i>including medical supplies</i>)  <a href="#">Diagnostic test</a> (<i>x-ray</i>)  <a href="#">Durable medical equipment</a> (<i>crutches</i>)  <a href="#">Rehabilitation services</a> (<i>physical therapy</i>)</p>	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<b><a href="#">Cost Sharing</a></b>		<b><a href="#">Cost Sharing</a></b>		<b><a href="#">Cost Sharing</a></b>	
<a href="#">Deductibles</a>	\$0	<a href="#">Deductibles</a>	\$0	<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$10	<a href="#">Copayments</a>	\$1,000	<a href="#">Copayments</a>	\$100
<a href="#">Coinsurance</a>	\$0	<a href="#">Coinsurance</a>	\$0	<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$70</b>	<b>The total Joe would pay is</b>	<b>\$1,020</b>	<b>The total Mia would pay is</b>	<b>\$100</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



## Language Access Services:

(TTY/TDD: 711)

**Albanian (Shqip):** Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (888) 224-4896

**Amharic (አማርኛ):** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በገና የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (888) 224-4896 ይደውሉ።

**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:

**Bassa (Bàsɔ̀ Wùdù):** M̄ dyi dyi-diè-djè b̄é b̄édjé b̄á céè-djè nià ke dyí ní, ɔ̀ m̀ò nì dyí-b̄édjèin-djè b̄é m̀ ké gbo-kpá-kpá kè b̄ǎ kpǎ djé m̀ b̄ídjí-wùdùùn b̄ó pídyi. B̄é m̀ ké wuɖu-zìin-nyò d̀ò gbo wùdù ke, d̄á (888) 224-4896.

**Bengali (বাংলা):** যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (888) 224-4896 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖု (888) 224-4896 သို့ ခေါ်ဆိုပါ။

**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(888) 224-4896。

**Dinka (Dinka):** Na nɔŋ thiëc në ke de yä thorë, ke yin nɔŋ loŋ bē yi kuony ku wër alëu bē gɛɛr yic yin ne thoŋ du ke cin wëu tāäuë ke piny. Te kør yin ba jam wënë ran ye thok geryic, ke yin cəl (888) 224-4896.

**Dutch (Nederlands):** Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (888) 224-4896.

**Farsi (فارسي):** در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (888) 224-4896 تماس بگیرید.

## Language Access Services:

**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 (888) 224-4896.

**German (Deutsch):** Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (888) 224-4896.

**Greek (Ελληνικά)** Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (888) 224-4896.

**Gujarati (ગુજરાતી):** જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (888) 224-4896.

**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.

**Hindi (हिंदी):** अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (888) 224-4896 ।

**Hmong (White Hmong):** Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (888) 224-4896.

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