Your summary of benefits

Anthem®

Anthem® Blue Cross and Blue Shield

Your Plan: STAFFORD:TOWN AND BOARD OF EDUCATION (Non Med Wrap): Anthem Century Preferred PPO HSA PS CSV

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	$1,500 person / $3,000 family	$1,500 person / $3,000 family
Out-of-Pocket Limit	$1,500 person / $3,000 family	$3,000 person / $6,000 family
The family deductible and out-of-pocket maximum are non-embedded meaning the cost shares of all family members apply to one shared family deductible and one shared family out-of-pocket maximum. The individual deductible and individual out-of-pocket maximum only apply to individuals enrolled under single coverage.		
Preventive Care / Screening / Immunization	No charge	20% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Specialist Care Visit	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Routine Prenatal Care	No charge	20% coinsurance after deductible is met
Routine Postnatal Care	No charge	20% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	0% 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
On-line Visit *Includes Mental Health and Substance Abuse* *Live Health Online is the preferred telehealth solution.* *(www.livehealthonline.com).*	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 50 visits per benefit period. (Chiropractic, PT, OT, ST combined)*	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Acupuncture	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Other Services in an Office:		
Allergy Testing	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Chemo/Radiation Therapy	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Dialysis/Hemodialysis	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Prescription Drugs - *Dispensed in the office*	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Diagnostic Services **Lab:**		
Office	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Freestanding/Site of Service Lab	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	20% coinsurance after deductible is met
X-Ray:		
Office	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Freestanding/Site of Service Radiology Center	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital	0% 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
Advanced Diagnostic Imaging:		
Office	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Freestanding/Site of Service Radiology Center	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Emergency Room Facility Services	0% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	0% coinsurance after deductible is met	Covered as In-Network
Ambulance	0% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Facility Visit:		
Facility Fees	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Doctor Services	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	0% 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
Freestanding Surgical Center	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Freestanding Surgical Center	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):		
Facility Fees *Coverage is for Inpatient rehabilitation is limited to 100 days per benefit period.*	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Doctor and other services	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 200 visits per benefit period.*	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Rehabilitation services:		
Office *Coverage for rehabilitative and habilitative physical therapy, occupational therapy, speech therapy, and manipulative treatment is limited to 50 visits combined per benefit period.*	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital *Coverage for rehabilitative and habilitative physical therapy, occupational therapy, speech therapy, and manipulative treatment is limited to 50 visits combined per benefit period.*	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Cardiac rehabilitation		
Office	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital	0% 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
Skilled Nursing Care (facility) *Coverage is limited to 120 days per benefit period.*	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Hospice	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Durable Medical Equipment	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Prosthetic Devices	0% coinsurance after deductible is met	20% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Combined with medical deductible	Combined with medical deductible
Pharmacy Out of Pocket	Combined with medical	Combined with medical
Prescription Drug Coverage *National Drug List* *This product has a 34-day Retail Pharmacy Network available. A 34 day supply is available at most retail pharmacies.*		
Tier 1 - Typically Generic *34 day supply (retail pharmacy). 100 day supply (home delivery).*	$0 copay per prescription after deductible is met (retail and home delivery)	20% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *34 day supply (retail pharmacy). 100 day supply (home delivery).*	$0 copay per prescription after deductible is met (retail and home delivery)	20% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *34 day supply (retail pharmacy). 100 day supply (home delivery).*	$0 copay per prescription after deductible is met (retail and home delivery)	20% coinsurance after deductible is met (retail) and Not covered (home delivery)

Notes:

- Your copays, coinsurance and deductible count toward your out of pocket amount.

- 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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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 (888) 224-4896

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(TTY/TDD: 711)

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Language Access Services:

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