

**CERTIFIED / UNAFFILIATED – HRA 2022-2023**

**(068861- 005)**

Anthem® Blue Cross and Blue Shield

Your Plan: REGIONAL SCHOOL DISTRICT #8 (Non Med Wrap): Anthem Century Preferred PPO HRA PS CSV NE

Your Network: Century Preferred

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b>	\$2,000 person / \$4,000 family	\$2,000 person / \$4,000 family
<b>Out-of-Pocket Limit</b>	\$2,000 person / \$4,000 family	\$4,000 person / \$8,000 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.		
<b>Preventive Care / Screening / Immunization</b>	No charge	20% coinsurance after deductible is met
<b><u>Doctor Home and Office Services</u></b>		
<b>Primary Care Visit</b>	0% coinsurance after deductible is met	20% coinsurance after deductible is met
<b>Specialist Care Visit</b>	0% coinsurance after deductible is met	20% coinsurance after deductible is met
<b>Routine Prenatal Care</b>	No charge	20% coinsurance after deductible is met
<b>Routine Postnatal Care</b>	No charge	20% coinsurance after deductible is met
<b><u>Other Practitioner Visits:</u></b>		
Retail Health Clinic	0% coinsurance after deductible is met	20% coinsurance after deductible is met
On-line Visit <i>Includes Mental Health and Substance Abuse Live Health Online is the preferred telehealth solution. (<a href="http://www.livehealthonline.com">www.livehealthonline.com</a>).</i>	0% coinsurance after deductible is met	20% coinsurance after deductible is met

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Questions: (888) 224-4896 or visit us at [www.anthem.com](http://www.anthem.com)

CT/LG/REGIONAL SCHOOL DISTRICT #8 (Non Med Wrap): Anthem Century Preferred PPO HRA PS CSV NE/5HFQ/07-01-2021

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Manipulation Therapy <i>Coverage is limited to 50 visits per benefit period.</i>	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
<b><u>Other Services in an Office:</u></b> Allergy Testing Chemo/Radiation Therapy Dialysis/Hemodialysis Prescription Drugs - <i>Dispensed in the office</i>	0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met
<b><u>Diagnostic Services</u></b> <b>Lab:</b> Office Freestanding/Site of Service Lab Outpatient Hospital	0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met
<b>X-Ray:</b> Office Freestanding/Site of Service Radiology Center Outpatient Hospital	0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met
<b>Advanced Diagnostic Imaging:</b> Office	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/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
<u><b>Emergency and Urgent Care</b></u> <b>Urgent Care</b>	0% coinsurance after deductible is met	20% coinsurance after deductible is met
<b>Emergency Room Facility Services</b>	0% coinsurance after deductible is met	Covered as In-Network
<b>Emergency Room Doctor and Other Services</b>	0% coinsurance after deductible is met	Covered as In-Network
<u><b>Ambulance</b></u>	0% coinsurance after deductible is met	Covered as In-Network
<u><b>Outpatient Mental/Behavioral Health and Substance Abuse</b></u> <b>Doctor Office Visit</b>  <b>Facility Visit:</b> Facility Fees  Doctor Services	0% coinsurance after deductible is met  0% coinsurance after deductible is met  0% coinsurance after deductible is met	20% coinsurance after deductible is met  20% coinsurance after deductible is met  20% coinsurance after deductible is met
<u><b>Outpatient Surgery</b></u> <b>Facility Fees:</b> Hospital  Freestanding Surgical Center  <b>Doctor and Other Services:</b> Hospital	0% coinsurance after deductible is met  0% coinsurance after deductible is met  0% coinsurance after deductible is met	20% coinsurance after deductible is met  20% 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
<p><b><u>Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):</u></b></p> <p><b>Facility Fees</b></p> <p><b>Doctor and other services</b></p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>
<p><b><u>Recovery &amp; Rehabilitation</u></b></p> <p><b>Home Health Care</b> <i>Coverage is limited to 200 visits per benefit period.</i></p>	0% coinsurance after deductible is met	20% coinsurance after deductible is met
<p><b>Rehabilitation services:</b></p> <p>Office <i>Coverage for rehabilitative and habilitative physical therapy, occupational therapy, speech therapy, and manipulative treatment is limited to 50 visits combined per benefit period.</i></p> <p>Outpatient Hospital <i>Coverage for rehabilitative and habilitative physical therapy, occupational therapy, speech therapy, and manipulative treatment is limited to 50 visits combined per benefit period.</i></p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>
<p><b>Cardiac rehabilitation</b></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>
<p><b>Skilled Nursing Care (facility)</b> <i>Coverage is limited to 220 days per benefit period.</i></p>	0% coinsurance after deductible is met	20% coinsurance after deductible is met
<b>Hospice</b>	0% coinsurance after deductible is met	20% coinsurance after deductible is met
<b>Durable Medical Equipment</b>	0% coinsurance after deductible is met	20% coinsurance after deductible is met
<b>Prosthetic Devices</b>	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
<b>Pharmacy Deductible</b>	Combined with medical deductible	Combined with medical deductible
<b>Pharmacy Out of Pocket</b>	Combined with medical	Combined with medical
<b>Prescription Drug Coverage</b> <i>National with R90</i> <i>National Drug List</i> <i>This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs.</i>		
<b>Tier 1 - Typically Generic</b> <i>30 day supply (retail pharmacy). 90 day supply (home delivery).</i>	\$5 copay per prescription after deductible is met (retail and home delivery)	20% coinsurance after deductible is met (retail) and Not covered (home delivery)
<b>Tier 2 – Typically Preferred Brand</b> <i>30 day supply (retail pharmacy). 90 day supply (home delivery).</i>	\$25 copay per prescription after deductible is met (retail and home delivery)	20% coinsurance after deductible is met (retail) and Not covered (home delivery)
<b>Tier 3 - Typically Non-Preferred Brand</b> <i>30 day supply (retail pharmacy). 90 day supply (home delivery).</i>	\$40 copay per prescription after deductible is met (retail and home delivery)	20% coinsurance after deductible is met (retail) and Not covered (home delivery)

**Notes:**

- **Requires prior authorization for imaging services.**
- 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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## 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

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

(TTY/TDD: 711)

**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.

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