Your summary of benefits

Anthem®

Anthem® Blue Cross and Blue Shield

Your Plan: REGIONAL SCHOOL DISTRICT #8 (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	$2,000 person / $4,000 family	$2,000 person / $4,000 family
Out-of-Pocket Limit	$5,000 person / $6,850 family	$5,000 person / $10,000 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 per person deductible and per person out-of-pocket maximum only apply to individuals enrolled under single coverage. Your copays, coinsurance and deductible count toward your out of pocket amount(s). In-network and out-of-network deductibles and out-of-pocket maximum amounts are combined and 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)	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Mental Health and Substance Abuse care	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Specialist	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
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	0% coinsurance after deductible is met	
Specialist Care	0% coinsurance after deductible is met	
Visits in an Office		
Primary Care (PCP)	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Specialist Care	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	No charge	20% coinsurance after deductible is met
Retail Health Clinic	0% coinsurance after deductible is met	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.*	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
Surgery	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
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
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
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 Health and Substance Abuse		
Doctor Office Visit	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
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
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 Health and Substance Abuse)		
Facility Fees	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 100 visits per benefit period.*	0% coinsurance after deductible is met	20% coinsurance after deductible is met
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	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
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
Skilled Nursing Care (facility) *Coverage is limited to 100 days per benefit period.*	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Inpatient 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 *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	0% coinsurance after deductible is met	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	Combined with In-Network medical deductible	Combined with Non-Network medical deductible
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. You may receive up to a 34 day supply of medication at Retail 34 pharmacies*		
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 and Retail 34 pharmacy). Per 100 day supply (home delivery).*	$5 copay per prescription after deductible is met (retail and home delivery)	20% coinsurance after deductible is met (retail) and Not Covered (home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Tier 2 – Typically Preferred Brand *Per 34 day supply (retail pharmacy and Retail 34 pharmacy). Per 100 day supply (home delivery).*	$25 copay per prescription after deductible is met (retail) and $50 copay per prescription after deductible is met (home delivery)	20% coinsurance after deductible is met (retail) and Not Covered (home delivery)
Tier 3 - Typically Non-Preferred Brand/Specialty Drugs *Per 34 day supply (retail pharmacy and Retail 34 pharmacy). Per 100 day supply (home delivery). Per 34 day (specialty pharmacy).*	$40 copay per prescription after deductible is met (retail) and $80 copay per prescription after deductible is met (home delivery)	20% coinsurance after deductible is met (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.		
Child Vision exam *Limited to 1 exam per benefit period.*	No charge	20% coinsurance after deductible is met
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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