Your summary of benefits

Anthem BlueCross BlueShield

Anthem Blue Cross and Blue Shield

Your Plan: CT Silver PPO Plan -2025

Your Network: Preferred Blue PPO

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 Certificate of Insurance or Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section. In-Network Providers and Non-Network Providers deductibles are combined. Satisfying one helps satisfy the other.* ***Additional deductible:** \$250 per member Durable Medical Equipment*	\$2,500 single / \$5,000 family	\$5,000 single / \$10,000 family
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum. In-Network Providers and Non-Network Providers Out of Pocket are combined. Satisfying one helps satisfy the other.*	\$7,000 single / \$12,000 family	\$15,000 single / \$30,000 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible. Contraceptive methods approved by FDA and prescribed for a woman by her health care provider, subject to reasonable medical management, will be covered without cost sharing requirements.*	No charge	50% coinsurance after deductible is met
Doctor Home and Office Services		
Primary care visit to treat an injury or illness	\$35 copay per visit	50% coinsurance after deductible is met
Specialist care visit	\$80 copay per visit	50% coinsurance after deductible is met

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Prenatal and Post-natal Care *In network preventive prenatal and postnatal services are covered at 100%.*	No charge	50% coinsurance after deductible is met
Other practitioner visits:		
Retail health clinic	$35 copay per visit	50% coinsurance after deductible is met
On-line Visit	$35 copay per visit	50% coinsurance after deductible is met
Chiropractor services *Limited to 20 visits combined in-network and non-network.*	$35 copay per visit	50% coinsurance after deductible is met
Acupuncture	Not covered	Not covered
Other services in an office:		
Allergy testing	No Charge	50% coinsurance after deductible is met
Chemo/radiation therapy	Subject to deductible	50% coinsurance after deductible is met
Hemodialysis	Subject to deductible	50% coinsurance after deductible is met
Prescription drugs *For the drugs itself dispensed in the office thru infusion/injection*	Subject to deductible	20% coinsurance after deductible is met
Diagnostic Services *Cost shares may vary if services are processed in a different location*		
Lab:		
Office	No charge	50% coinsurance after deductible is met
Freestanding Lab	No charge	50% coinsurance after deductible is met

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Outpatient Hospital	Subject to deductible	50% coinsurance after deductible is met
X-ray:		
Office	No Charge	50% coinsurance after deductible is met
Freestanding Radiology Center	No Charge	50% coinsurance after deductible is met
Outpatient Hospital	Subject to deductible	50% coinsurance after deductible is met
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office	$500 copay per visit after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	$500 copay per visit after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	$500 copay per visit after deductible is met	50% coinsurance after deductible is met
Emergency and Urgent Care		
Emergency room facility services *Copay waived if admitted.*	$250 copay per visit after deductible is met	$250 copay per visit after deductible is met
Emergency room doctor and other services	No Charge	No Charge
Ambulance (air and ground)	Subject to deductible	Subject to in-network deductible
Urgent Care (facility setting)		
Facility fees	$100 copay per visit	$100 copay per visit
Doctor and other services	No Charge	No Charge

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Urgent Care (office visit)	$100 copay per visit	$100 copay per visit
Other Services *In-Network Urgent Care benefit limited to preferred New Hampshire locations.*	No Charge	No Charge
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit	$35 copay per visit	50% coinsurance after deductible is met
Facility visit:	Subject to deductible	50% coinsurance after deductible is met
Outpatient Surgery		
Facility fees:		
Hospital	$750 copay per visit after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	$750 copay per visit after deductible is met	50% coinsurance after deductible is met
Doctor and other services		
Hospital	Subject to deductible	50% coinsurance after deductible is met
Freestanding Surgical Center	Subject to deductible	50% coinsurance after deductible is met
Anesthesiology	$250 copay per visit after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)		
Facility fees (for example, room & board)	$1,000 copay per visit after deductible is met	50% coinsurance after deductible is met
Doctor and other services	Subject to deductible	50% coinsurance after deductible is met
Anesthesiology	$250 copay per visit after deductible is met	50% coinsurance after deductible is met
Recovery & Rehabilitation		
Home health care	Subject to deductible	50% coinsurance after deductible is met
Rehabilitation and Habilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for Physical Therapy is limited to 20 visit per benefit period, Speech Therapy is limited to 20 visit limit per benefit period and Occupational Therapy is limited to 20 visits per benefit period. Apply to In-Network & Non Network providers. Visit limit is combined for office and outpatient hospital.*	$35 copay per visit	50% coinsurance after deductible is met
Outpatient hospital *Coverage for Physical Therapy is limited to 20 visit per benefit period, Speech Therapy is limited to 20 visit limit per benefit period and Occupational Therapy is limited to 20 visits per benefit period. Apply to In-Network & Non Network providers. Visit limit is combined for office and outpatient hospital.*	$35 copay per visit	50% coinsurance after deductible is met
Cardiac rehabilitation		

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Cardiac rehabilitation Office Outpatient hospital	 $80 copay per visit Subject to deductible	50% coinsurance after deductible is met Not Covered
Skilled nursing care (in a facility) *Coverage for In-Network Providers is limited to 100 day limit per benefit period. Inpatient physical rehabilitation is limited to 100 days per benefit period.*	Subject to deductible	50% coinsurance after deductible is met
Hospice	Subject to deductible	50% coinsurance after deductible is met
Durable Medical Equipment	Subject to overall deductible, $250 DME deductible	Subject to overall deductible, $250 DME deductible
Prosthetic Devices	Subject to overall deductible, $250 DME deductible	Subject to overall deductible, $250 DME deductible

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Notes:

- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.
- For additional information on this plan, please visit sbc.anthem.com to obtain a "Summary of Benefit Coverage".
- To view your prescription formulary list log on to www.anthem.com/health-insurance/customer-care/forms-library
- Your copays, coinsurance and deductible count toward your out of pocket amount. Your adult Vision benefit cost sharing still applies after your out-of-pocket limit is met.
- Vision services are not subject to the annual deductible.
- The services listed below are not covered by this plan. Complete details on exclusions and limitations are stated in the Subscriber Certificate. • Any service that is not medically necessary • Any service required by a third party (court ordered services are covered if all of the other terms of the plan are met) • Cosmetic surgery • Custodial or convalescent care • Educational testing and therapy •Experimental and/or investigational services except as required by law for clinical trials • Hospitalization for conditions that are not covered •Human organ transplants other than those listed in the Subscriber Certificate as Covered Services • Mental health services which do not usually result in favorable modification through therapy • Permanent dental restoration, (general anesthesia, hospital or surgical day care facility charges for dental procedures are covered for certain individuals only to the extent required by law) • Personal comfort items • Radial keratotomy or other surgery to correct vision • Routine podiatry • Services covered by government programs to the extent permitted by law • Services for work-related illness or injury • Services, treatments, procedures or programs for weight or appetite control, weight loss, weight management or control of obesity, except for diabetes education, nutrition counseling, and medically necessary surgical and non-surgical services to treat diseases and ailments caused by or resulting from obesity or morbid obesity
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.

Questions:(855) 333-5735 or visit us at www.anthem.com
NH/L/T7/6/PBVP209VM 1000/10% 7150/01-18

Your summary of benefits

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 (855) 333-5735.

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 333-5735 (855).

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՝ (855) 333-5735:

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 (855) 333-5735。

Farsi (فارسي) : در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره 333-5735 (855) تماس بگیرید.

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 (855) 333-5735.

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 (855) 333-5735.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (855) 333-5735.

Japanese (日本語):この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。 通訳と話すには、(855) 333-5735 にお電話ください。

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Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (855) 333-5735 로 문의하십시오.

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bína'ídiłkidgo ná bohónéedzą́ dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínízingo kojí' hodíilnih (855) 333-5735.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: (855) 333-5735.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (855) 333-5735 ਤੇ ਕਾਲ ਕਰੋ।

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (855) 333-5735.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (855) 333-5735.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (855) 333-5735.

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (855) 333-5735.

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available ahttp://www.hhs.gov/ocr/office/file/index.html

Connecticut Prescription Drug Coverage
2025 Silver PPO Plan

Administered by Express Scripts/Medco
~ (800) 711-0917 ~ www.express-scripts.com

Retail Copay (30 day supply)

Generic	$15
Brand	$50
Non-Preferred Brand	$100
Specialty	$150

Mail Order Copay (90 day supply)

Generic	$37.50
Brand	$150
Non-Preferred Brand	$300
Specialty	$450