Your summary of benefits

Anthem Blue Cross and Blue Shield

Your Plan: CT Silver H.S.A Plan -2025

Your Network: Preferred Blue

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.*	$4,000 single / $8,000 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.*	$7,250 single / $12,500 family	$15,000 single / $30,000 family
Preventive care/screening/immunization *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	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Specialist care visit	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Prenatal and Post-natal Care *In network preventive prenatal and postnatal services are covered at 100%.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met

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Other practitioner visits:		
Retail health clinic	20% coinsurance after deductible is met	50% coinsurance after deductible is met
On-line Visit	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Chiropractor services *Up to 12 visits per member, per calendar year.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Acupuncture	Not covered	Not covered
Other services in an office:		
Allergy testing	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Chemo/radiation therapy	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hemodialysis	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Prescription drugs *For the drugs itself dispensed in the office thru infusion/injection*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Diagnostic Services		
Lab:		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Lab	20% coinsurance after deductible is met	50% coinsurance after deductible is met

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Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
X-ray:		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency and Urgent Care		
Emergency room facility services	20% coinsurance after deductible is met	20% coinsurance after in network deductible is met
Emergency room doctor and other services	20% coinsurance after deductible is met	20% coinsurance after in network deductible is met
Ambulance (air and ground)	20% coinsurance after deductible is met	20% coinsurance after in network deductible is met

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Urgent Care (facility setting)		
Facility fees	20% coinsurance after deductible is met	20% coinsurance after in network deductible is met
Doctor and other services	20% coinsurance after deductible is met	20% coinsurance after in network deductible is met
Urgent Care (office visit)	20% coinsurance after deductible is met	20% coinsurance after in network deductible is met
Other Services	20% coinsurance after deductible is met	20% coinsurance after in network deductible is met
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Facility visit:	20% coinsurance after deductible is met	50% coinsurance after deductible is met

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Outpatient Surgery		
Facility fees:		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and other services Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Anesthesiology	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)		
Facility fees (for example, room & board)	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Anesthesiology	20% coinsurance after deductible is met	50% coinsurance after deductible is met

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Recovery & Rehabilitation		
Home health care	20% coinsurance after deductible is met	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 visits per benefit period, Speech Therapy is limited to 20 visits per benefit period, and Occupational Therapy is limited to 20 visits per benefit period.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient hospital *Coverage for Physical Therapy is limited to 20 visits per benefit period, Speech Therapy is limited to 20 visits per benefit period, and Occupational Therapy is limited to 20 visits per benefit period.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled nursing care (in a facility) *Coverage for In-Network Providers is limited to 100 days per benefit period. Separate limit of 100 days annual max for inpatient physical rehabilitation.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospice	20% coinsurance after deductible is met	50% coinsurance after deductible is met

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Durable Medical Equipment	20% coinsurance after deductible is met	20% coinsurance after in network deductible is met
Prosthetic Devices	20% coinsurance after deductible is met	20% coinsurance after deductible is met

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Notes:

- Non-Embedded: The Out-of-Pocket Limit includes all Deductibles, Coinsurance, and Copayments you pay during a Benefit Period. If you are covered under a single membership and you meet your Out-of-Pocket Limit, you will not have to pay additional Deductible, Coinsurance or Copayments for the rest of the Benefit Period. If you are covered under a family membership and the family Out-of-Pocket Limit is met, no family Member will have to pay additional Deductible, Coinsurance or Copayments for the rest of the Benefit Period. One Member or all Members collectively can satisfy the family Out-of-Pocket Limit. The Out-of-Pocket Limit does not include your premium, amounts over the Maximum Allowed Amount or charges for non-covered services.
- 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, most oral surgery (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.

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 (855) 333-5735.

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。

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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.

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Language Access Services:

Navajo (Diné): **Díí naaltsoos biká'ígíí łahgo bína'idilkidgo ná bohónéedzą́ dóó bee ahóót'i' t'áá ni nizaad k'ehjį bee nił hodoonih t'áadoo bááh ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínízingo kojį' hodíílnih** (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.

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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.

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Connecticut Prescription Drug Coverage
2025 Silver HSA

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

Copays apply ***after*** the H.S.A deductible has been met (medical and prescription).

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