



CENTURY PREFERRED \$25-\$30/\$250/\$125/\$250

Century Preferred is a preferred provider organization (PPO) plan.

COST SHARE PROVISIONS	In-Network Member pays:	Out-of-Network Member pays:
Office Visit (OV) Copayment	\$25 per visit	Deductible & Coinsurance
Specialist Visit (SV) Copayment	\$30 per visit	Deductible & Coinsurance
Hospital (HSP) Copayment	\$250 per admission	Deductible & Coinsurance
Urgent Care (UR) Copayment	\$75	Not Covered
Emergency Room (ER) Copayment – <i>waived if admitted</i>	\$125	\$125
Outpatient Surgery (OS) Copayment	\$250	Deductible & Coinsurance
Calendar Year Deductible (<i>individual/2-member family/3+ member family</i>)	Not Applicable	\$250/\$750
Coinsurance		20% after deductible up to
Coinsurance Maximum (<i>individual/2-member family/3+ member family</i>)		\$700/\$2,100
Cost Share Maximum (<i>individual/2-member family/3+ member family</i>)		\$950/\$2,850
Lifetime Maximum	Unlimited	Unlimited

PREVENTIVE CARE

Well child care	\$0 Copayment	Deductible & Coinsurance
Periodic, routine health examinations	\$0 Copayment	
Routine OB/GYN visits	\$0 Copayment	
Mammography	No Charge	
Hearing exam -	\$30 Copayment	
Routine Eye Exam –		

MEDICAL CARE

Office visits	OV Copayment	Deductible & Coinsurance
Outpatient mental health & substance abuse	OV Copayment	
OB/GYN care	SV Copayment	
Maternity care – <i>initial visit subject to copayment, no charge thereafter</i>	SV Copayment	
Diagnostic lab and x-ray	No Charge	
High-cost outpatient diagnostic	No Copayment	
Allergy services <i>Office visits/testing</i> <i>Injections—80 visits in 3 years</i>	SV Copayment No Copayment	

HOSPITAL CARE – Prior authorization required

Semi-private room (<i>General/Medical/Surgical/Maternity</i>)	\$250 Copayment	Deductible & Coinsurance
Inpatient mental health & substance abuse	\$250 Copayment	
Skilled nursing facility – <i>up to 120 days per calendar year</i>	\$250 Copayment	
Rehabilitative services – <i>up to 60 days per person per calendar year</i>	No Charge	
Outpatient surgery – <i>in a hospital or surgi-center</i>	\$250 Copayment	

EMERGENCY CARE

Walk-in centers	OV Copayment	Deductible & Coinsurance
Urgent care – <i>at participating centers only</i>	UR Copayment	Not Covered
Emergency care – <i>copayment waived if admitted</i>	ER Copayment	ER Copayment
Ambulance	No Charge	No Charge

OTHER SERVICES

Outpatient rehabilitative services <i>50 combined visit maximum for PT, OT, ST and Chiro per calendar year</i>	SV Copayment	Deductible & Coinsurance
Durable medical equipment / Prosthetic devices <i>Unlimited maximum per calendar year</i>	\$0 Copayment	Deductible & 20% Coinsurance
Infertility services – <i>No age or cycle restrictions</i>	Applicable Copayment	Deductible & Coinsurance
Home health care -300 visit maximum, 80 Home health Aide visits.	No Charge	\$50 Deductible & 20 % Coinsurance

PREVENTIVE CARE SCHEDULES

Well Child Care (including immunizations)

- ◆ 7 exams, ages 0 – 1 yr
- ◆ 7 exams, ages 1 to 5 years
- ◆ 1 exam, ages 5 – 12 years
- ◆ 1 exam – ages 5-22 years

Mammography

- ◆ 1 baseline screening, ages 35-39
- ◆ 1 screening per year, ages 40+
- ◆ Additional exams when medically necessary

Adult Exams

- ◆ 1 exam every years – ages 22+

Vision Exams: 1 exam every 2 calendar years

Hearing Exams: 1 exam every 2 calendar years

OB/GYN Exams: 1 exam per calendar year

Notes To Benefit Descriptions

- ◆ In situations where the member is responsible for obtaining the necessary prior authorization and fails to do so, benefits may be reduced or denied.
- ◆ Inpatient Hospital Per Admission Copay is waived if readmitted within 30 days for same diagnosis.
- ◆ Skilled Nursing Facility Copay is waived if admitted within 3 days of hospital discharge.
- ◆ Home Health Care services are covered when in lieu of hospitalization. Includes infusion (IV) therapy.
- ◆ Members are responsible for the balance of charges billed by out-of-network providers after payment for covered services has been made by Anthem Blue Cross and Blue Shield according to the Comprehensive Schedule of Professional Services.
- * Allowance for progressive lenses is equal to bifocal amount. Member pays amount in excess of maximum payable

Please refer to the *SpecialOffers@Anthem* brochure in your enrollment kit for information on the discounts we offer on health-related products and services.

This does not constitute your health plan or insurance policy. It is only a general description of the plan. The following are examples of services NOT covered by your Century Preferred Plan. Please refer to your Subscriber Agreement/Certificate of Coverage/Summary Booklet for more details: Cosmetic surgeries and services; custodial care; genetic testing; hearing aids; refractive eye surgery; services and supplies related to, as well as the performance of, sex change operations; surgical and non-surgical services related to TMJ syndrome; travel expenses; vision therapy; services rendered prior to your contract effective date or rendered after your contract termination date; and workers' compensation.

A product of Anthem Blue Cross and Blue Shield serving residents and businesses in the State of Connecticut.

Public Sector Managed RX, 3 Tier
Benefits at a Glance

\$5 COPAYMENT GENERIC DRUGS
\$25 COPAYMENT LISTED BRAND-NAME DRUGS
\$40 COPAYMENT NON-LISTED BRAND-NAME DRUGS
\$2,000 Annual Maximum

How To Use 3-Tier Managed Rx

3-Tier Managed Rx has three different levels (or “tiers”) of copayments, depending on the type of prescription drug you purchase (see the chart below for details). Your copayments will be lower when you use generic or brand-name medications that are on our list of preferred prescription drugs. The medications on this list are selected for their quality, safety and cost-effectiveness. You’ll still have coverage brand-name drugs that are not on the list, but your copayment will be higher.

Talk to your provider about using generic drugs or listed brand-name drugs. It’s a simple way to save out-of-pocket expenses.

Copayments and Day Supplies

- You will be responsible for **one** copayment when purchasing a **30-day supply** of prescription drugs from a retail pharmacy.
- You’ll be responsible for **Two copayments** when purchasing a **31-day to 90-day supply** of maintenance drugs through the voluntary mail-service program (see chart for details).

Generic Drugs Have the Lowest Copayment

Your copayment:

Tier 1: Generic drugs	The term “generic” refers to a prescription drug that is not protected by a trademark. It is required to meet the same bioequivalency test as the original brand-name drug. Tier 1 copayment applies.	\$5
Tier 2: Listed brand-name drugs	The term “listed brand-name” refers to a brand-name prescription drug that is on Anthem Blue Cross and Blue Shield’s list of preferred prescription drugs. Tier 2 copayment applies.	\$25
Tier 3: Non-listed brand-name drugs	The term “non-listed brand-name” refers to a brand-name prescription drug that is not on Anthem Blue Cross and Blue Shield’s list of preferred prescription drugs. Tier 3 copayment applies.	\$40
Mail Service	Two copayments per 31 day or 90 unit dose	\$10 generic/\$50 listed brand/ \$80 non-listed brand
Annual Maximum	Per member per calendar year	\$2,000

Generic Substitution

Prescriptions will be filled with the generic equivalent when there is one available. Exception: If your doctor indicates "Dispense as Written." In this case you will receive the brand-name drug—and you will be responsible for the applicable listed brand or non-listed brand copayment. NOTE: If your doctor does *not* indicate "Dispense as Written," you will be responsible for the applicable listed brand or non-listed brand-name copayment as well as the difference in cost between the generic and listed brand or non-listed brand name drug.

Voluntary Mail-Service Program

Anthem Rx, our voluntary mail-service drug program, can save you time and expense if you regularly take one or more types of maintenance drugs. You can order up to a **90-day supply** of these medications and have them delivered directly to your home.

Two mail-service copayments will apply as follows: \$10 generic/\$50 listed brand/\$80 non-listed brand

National Pharmacy Network

Members also have access to a network of more than 53,000 retail pharmacies throughout the country. Members may call 1-888-207-4214, or go to www.anthemprescription.com, to locate a participating pharmacy when traveling outside the state.

Non-Participating Pharmacies

Members who fill prescriptions at a non-participating pharmacy are responsible for payment at the time the prescription is filled. Members must submit claims to Anthem Blue Cross and Blue Shield for reimbursement, and payment will be sent to the member. Members who use non-participating pharmacies will pay 20% of the in-network allowance, plus the difference between Anthem Blue Cross and Blue Shield's payment and the pharmacist's actual charge.

Limits and Exclusions

Benefits are limited to no more than a **30-day supply** for covered drugs purchased at a retail pharmacy, and no more than a **90-day supply** for covered drugs purchased by mail service. All prescriptions are subject to the quantity limitations imposed by state and federal statutes.

Benefits for prescription birth control and Sexual Dysfunction medications are covered.

This is not a legal contract. It is only a general description of the Managed Rx, 3 Tier version. Please consult the Evidence of Coverage or prescription drug rider for a complete description of benefits and exclusions applicable to your coverage.



Lumenos HSA Plan Summary

The Lumenos[®] HSA plan is designed to empower you to take control of your health, as well as the dollars you spend on your health care. This plan gives you the benefits you would receive from a typical health plan, plus health care dollars to spend your way. And you'll have access to personalized services and online tools to help you reach your health potential.

Your Lumenos HSA Plan

First – Use your HSA to pay for covered services:

Health Savings Account

With the Lumenos Health Savings Account (HSA), you can contribute pre-tax dollars to your HSA account. Others may also contribute dollars to your account. You can use these dollars to help meet your annual deductible responsibility. Unused dollars can be saved or invested and accumulate through retirement.

Contributions to Your HSA

For 2018, contributions can be made to your HSA up to the following:
\$3,450 individual coverage
\$6,900 family coverage

Note: These limits apply to all combined contributions from any source including HSA dollars from incentives.

Earn More Money for Your Account

What's special about your Lumenos HSA plan is that you may earn additional funds for your health account through the Healthy Rewards incentive program.

Earn Rewards

If you do this:

- Future Moms for participation and completion
- Healthy Lifestyles online participation
- ConditionCare participation and completion.

You can earn:

Up to \$200
Up to \$150
Up to \$300

Some eligibility requirements apply. See page 2 for program descriptions.

To receive funds earned through the Healthy Rewards program, you must have an open HSA with Mellon Bank or with another bank through which your employer is sponsoring your HSA.

Plus – To help you stay healthy, use:

Preventive Care

100% coverage for nationally recommended services. Included are the preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.

Preventive Care

No deductions from the HSA or out-of-pocket costs for you as long as you receive your preventive care from an in-network provider. If you choose to go to an out-of-network provider, your deductible or Traditional Health Coverage benefits will apply.

Then –

Your Bridge Responsibility

The Bridge is an amount you pay out of your pocket until you meet your annual deductible responsibility. Your bridge amount will vary depending on how many of your HSA dollars, if any, you choose to spend to help you meet your annual deductible responsibility. If you contribute HSA dollars up to the amount of your deductible and use them, your Bridge will equal \$0.

HSA dollars spent on covered services plus your Bridge responsibility add up to your annual deductible responsibility.

Health Account + Bridge = Deductible

Bridge

Your Bridge responsibility will vary.

Annual Deductible Responsibility In Network and Out of Network Providers

\$2,000 individual coverage
\$4,000 family coverage

If Needed –

Traditional Health Coverage

Your Traditional Health Coverage begins after you have met your Bridge responsibility.

Traditional Health Coverage

After your bridge, the plan pays:

100% for in-network providers 80% for out-of-network providers

Additional Protection

For your protection, the total amount you spend out of your pocket is limited. Once you spend that amount, the plan pays 100% of the cost for covered services for the remainder of the plan year.

Annual Out-of-Pocket Maximum

In-Network Providers	Out-of-Network Providers
\$ 2,000 individual coverage	\$4,000 individual coverage
\$ 4,000 family coverage	\$8,000 family coverage

Your annual out-of-pocket maximum consists of funds you spend from your HSA, your Bridge responsibility and your coinsurance amounts.

If you have questions, please call toll-free 1-888-224-4896.



Healthy Rewards Program

Your employer will provide you with additional health care dollars in your HSA for the following:

Future Moms: Individualized obstetric support for expectant high-risk and non-high-risk mothers. Members can earn up to a \$200 Future Mom's incentive. This includes three milestones: \$100 initial enrollment, \$50 interim, and \$50 postpartum; timing and rules apply.

Healthy Lifestyles Online: Each adult family member can earn up to \$150 each year. Members earn a \$50 incentive at each 3,000, 5,000 and 10,000 point milestone. Your employees can quickly achieve their first milestone of 3,000 points by completing the Well-Being Assessment and setting up their Well-Being Plan.

Enroll in ConditionCare: (Incentive \$100) Disease management for prevalent, high-cost conditions (asthma, diabetes, chronic obstructive pulmonary disease, coronary artery disease and heart failure) . Each family member can get one incentive per year. In the first year and later years, members must stay qualified to enroll and earn incentives. Members who have more than one health problem will enroll in one combined program — not separate ones for each condition.

Graduate from ConditionCare: (Incentive \$200) There's no limit to the number of family members that can graduate and earn the incentive. Each family member can earn one credit per year. In the first year and later years, members must stay qualified to enroll, graduate and earn incentives. Members who have more than one health problem will graduate from one combined program — not separate ones for each condition.

To receive funds earned through Healthy Rewards, you must have an open HSA with Mellon Bank or with another bank through which your employer is sponsoring your HSA.

Summary of Covered Services

Preventive Care

Anthem's Lumenos HSA plan covers preventive services recommended by the U.S. Preventive Services Task Force, the American Cancer Society, the Advisory Committee on Immunization Practices (ACIP) and the American Academy of Pediatrics. The Preventive Care benefit includes screening tests, immunizations and counseling services designed to detect and treat medical conditions to prevent avoidable premature injury, illness and death.

All preventive services received from an in-network provider are covered at 100%, are not deducted from your HSA and do not apply to your deductible. If you see an out-of-network provider, then your deductible or out-of-network coinsurance responsibility will apply.

The following is a list of covered preventive care services:

Well Baby and Well Child Preventive Care

Office Visits through age 18; including preventive vision exams.

Screening Tests for vision, hearing, and lead exposure. Also includes pelvic exam, Pap test and contraceptive management for females who are age 18, or have been sexually active.

Immunizations:

- Hepatitis A
- Hepatitis B
- Diphtheria, Tetanus, Pertussis (DtaP)
- Varicella (chicken pox)
- Influenza – flu shot
- Pneumococcal Conjugate (pneumonia)
- Human Papilloma Virus (HPV) – cervical cancer
- H. Influenza type b
- Polio
- Measles, Mumps, Rubella (MMR)

Adult Preventive Care

Office Visits after age 18; including preventive vision exams.

Screening Tests for vision, hearing, coronary artery disease, colorectal cancer, prostate cancer, diabetes, and osteoporosis. Also includes mammograms, as well as pelvic exams, Pap test and contraceptive management.

Immunizations:

- Hepatitis A
- Hepatitis B
- Diphtheria, Tetanus, Pertussis (DtaP)
- Varicella (chicken pox)
- Influenza – flu shot
- Pneumococcal Conjugate (pneumonia)
- Human Papilloma Virus (HPV) – cervical cancer

If you have questions, please call toll-free 1-888-224-4896.

Summary of Covered Services (Continued)

Medical Care

Anthem's Lumenos HSA plan covers a wide range of medical services to treat an illness or injury. You can use your available HSA funds to pay for these covered services. Once you spend up to your deductible amount for covered services, you will have Traditional Health Coverage available to help pay for additional covered services.

The following is a summary of covered medical services under Anthem's Lumenos HSA plan:

- Physician Office Visits
- Inpatient Hospital Services
- Outpatient Surgery Services
- Diagnostic X-rays/Lab Tests
- Emergency Hospital Services
- Inpatient and Outpatient Mental Health and Substance Abuse Services
- Maternity Care
- Chiropractic Care
- Prescription Drugs
- Home health care and hospice care
- Physical, Speech and Occupational Therapy Services
- Durable Medical Equipment

Some covered services may have limitations or other restrictions.* With Anthem's Lumenos HSA plan, the following services are limited:

- Skilled nursing facility services limited to 120 days per calendar year.
- Home health care services are limited to 200 visits per calendar year.
- Inpatient rehabilitative services limited to 100 days per member per calendar year.
- Physical, speech and occupational therapy and chiropractic services limited to a combined total of 50 visits per member per calendar year.
- Inpatient hospitalizations require authorizations.
- Your Lumenos HSA plan includes an unlimited lifetime maximum for in- and out-of-network services.

* For a complete list of exclusions and limitations, please reference your Certificate of Coverage.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

If you have questions, please call toll-free 1-888-224-4896.



Lumenos HSA Plan Summary



This summary is a brief outline of the benefits and coverage provided under the Lumenos plan. It is not intended to be a complete list of the benefits of the plan. This summary is for a full year in the Lumenos plan. If you join the plan mid-year or have a qualified change of status, your actual benefit levels may vary.

Additional limitations and exclusions may apply.



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If you have questions, please call toll-free 1-888-224-4896.