

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: TOWN OF NEWTOWN (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	\$2,250 person / \$4,500 family	\$2,250 person / \$4,500 family
Overall Out-of-Pocket Limit	\$3,250 person / \$6,500 family	\$5,500 person / \$11,000 family
<p>The family deductible and out-of-pocket limit are non-embedded, meaning the cost shares of all family members apply to one family deductible and one family out-of-pocket limit. The per person deductible and per person out-of-pocket limit apply to individuals enrolled under single-only coverage.</p> <p>Your copays, coinsurance and deductible count toward your out of pocket limit(s).</p> <p>The In-Network and Non-Network deductibles are combined and accumulate toward each other. The In-Network and NonNetwork out-of-pocket limit amounts accumulate toward each other.</p>		
<p>Doctor Visits (virtual and office) <i>You are encouraged to select a Primary Care Physician (PCP).</i></p>		
<p>Virtual Visits from online provider LiveHealth Online <i>for urgent/acute medical and mental health and substance abuse care via www.livehealthonline.com are covered at 0% coinsurance after deductible is met; and 0% coinsurance after deductible is met for covered Specialist Care.</i></p>		
<p>Primary Care (PCP) and Mental Health and Substance Abuse Care <i>virtual and office</i></p> <p>Specialist Care <i>virtual and office</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><u>Other Practitioner Visits</u></p>		
<p>Routine Maternity Care (Prenatal and Postnatal)</p>	No charge	20% coinsurance after deductible is met
<p>Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i></p>	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

CT/LG/TOWN OF NEWTOWN (Non Med Wrap): Anthem Century Preferred PPO HSA PS CSV/6FM4/07-01-2023

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Manipulation Therapy <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>	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
<u>Other Services in an Office</u> Allergy Testing Prescription Drugs <i>Dispensed in the office</i> Surgery	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
Preventive care / screenings / immunizations	No charge	20% coinsurance after deductible is met
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	20% coinsurance after deductible is met
<u>Diagnostic Services</u> Lab 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
X-Ray 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
Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i> Office Freestanding/Site of Service Radiology Center	0% coinsurance after deductible is met 0% coinsurance after	20% coinsurance after deductible is met 20% coinsurance after

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	deductible is met 0% coinsurance after deductible is met	deductible is met 20% coinsurance after deductible is met
<u>Emergency and Urgent Care</u> Urgent Care Emergency Room Facility Services Emergency Room Doctor and Other Services Ambulance	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 Covered as In-Network Covered as In-Network Covered as In-Network
<u>Outpatient Mental Health and Substance Abuse Care at a Facility</u> Facility Fees Doctor Services	0% coinsurance after deductible is met 0% coinsurance after deductible is met	20% coinsurance after deductible is met 20% coinsurance after deductible is met
<u>Outpatient Surgery</u> Facility Fees Hospital Ambulatory Surgical Center/Site of Service Provider Doctor and Other Services Hospital Ambulatory Surgical Center/Site of Service Provider	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
<u>Hospital (Including Maternity, Mental Health and Substance Abuse)</u> Facility Fees Physician and other services <i>including surgeon fees</i>	0% coinsurance after deductible is met 0% coinsurance after deductible is met	20% coinsurance after deductible is met 20% coinsurance after deductible is met
Home Health Care <i>Coverage is limited to 200 visits per benefit period.</i>	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
<p>Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies.</i> <i>Coverage for physical, occupational and speech therapies and manipulative treatment is limited to 50 visits combined per benefit period.</i></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>Pulmonary rehabilitation <i>office and outpatient hospital</i></p>	<p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p>Cardiac rehabilitation <i>office and outpatient hospital</i></p>	<p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p>Dialysis/Hemodialysis <i>office and outpatient hospital</i></p>	<p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p>Chemo/Radiation Therapy <i>office and outpatient hospital</i></p>	<p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p>Skilled Nursing Care (facility) <i>Coverage is limited to 120 days per benefit period.</i></p>	<p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p>Inpatient Hospice</p>	<p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p>Durable Medical Equipment</p>	<p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p>Prosthetic Devices <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i></p>	<p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p>Hearing Aids <i>Coverage is limited to 1 item per ear every 2 benefit periods.</i></p>	<p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<p>Pharmacy Deductible</p>	<p>Combined with In-Network medical deductible</p>	<p>Combined with Non-Network medical deductible</p>

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
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 Network: Base Network Drug List: National <i>If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.</i>		
Day Supply Limits: Retail Pharmacy 30 day supply (cost shares noted below) Home Delivery Pharmacy 90 day supply (maximum cost shares noted below) <i>Maintenance medications are available through CarelonRx Mail (IngenioRx will become CarelonRx on January 1, 2023). You will need to call us on the number on your ID card to sign up when you first use the service.</i> Specialty Pharmacy 30 day supply (cost shares noted below for retail and home delivery apply). <i>We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.</i>		
Tier 1 - Typically Generic	\$10 copay per prescription after deductible is met (retail and home delivery)	20% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand	\$30 copay per prescription after deductible is met (retail) and \$60 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	\$50 copay per prescription after deductible is met (retail) and \$100 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
<i>This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.</i>		
Child Vision exam <i>Limited to 1 exam per benefit period.</i>	No charge	20% coinsurance after deductible is met
Adult Vision exam <i>Limited to 1 exam per benefit period.</i>	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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