

Your summary of benefits



Anthem Blue Cross and Blue Shield, Newtown BOE H S A Teachers and Administrators

Your Plan: Anthem Century Preferred PPO H S A \$2,250/\$4,500

Your Network: Century Preferred RX copays \$10/\$30/\$50

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 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 <i>See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.</i>	\$2,250 person / \$4,500 family	
Out-of-Pocket Limit <i>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.</i>	\$3,250 person / \$6,500 family	\$5,500 person / \$11,000 family
Preventive care/screening/immunization <i>In-network preventive care is not subject to deductible, if your plan has a deductible. Included are the preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.</i>	No charge	20% coinsurance after deductible is met
Doctor Home and Office Services Primary care visit to treat an injury or illness	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Specialist care visit	0% coinsurance after deductible is met	20% coinsurance after deductible is met

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<p>Routine Prenatal Care</p>	<p>No Charge</p>	<p>20% coinsurance after deductible is met</p>
<p>Routine Postnatal Care</p>	<p>No Charge</p>	<p>20% coinsurance after deductible is met</p>
<p>Other practitioner visits: Retail health clinic</p> <p>On-line Medical Visit <i>Live Health Online is the preferred telehealth solutions (www.livehealthonline.com)</i></p> <p>Acupuncture <i>Covered</i></p>	<p>0% coinsurance after deductible is met</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>20% coinsurance after deductible is met</p>
<p>Other services in an office: Allergy testing</p> <p>Chemo/radiation therapy</p> <p>Dialysis/Hemodialysis</p> <p>Prescription drugs <i>For the drugs itself dispensed in the office thru infusion/injection.</i></p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</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>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>

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<p>Diagnostic Services</p> <p>Lab:</p> <ul style="list-style-type: none"> Office Freestanding/Site-of-Service Lab Outpatient Hospital 	<ul style="list-style-type: none"> 0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met 	<ul style="list-style-type: none"> 20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met
<p>X-ray:</p> <ul style="list-style-type: none"> Office Freestanding/Site-of-Service Radiology Center Outpatient Hospital 	<ul style="list-style-type: none"> 0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met 	<ul style="list-style-type: none"> 20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met
<p>Advanced Diagnostic Imaging: <i>Imaging services include MRI, MRA, CAT, CTA, PET, and SPECT scans</i></p> <ul style="list-style-type: none"> Office Freestanding/Site-of-Service Radiology Center Outpatient Hospital 	<ul style="list-style-type: none"> 0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met 	<ul style="list-style-type: none"> 20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met

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<p>Emergency and Urgent Care</p> <p>Urgent Care</p> <p>Emergency Room Facility Services</p> <p>Emergency room doctor and other services</p> <p>Ambulance Transportation</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</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>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p>Outpatient Mental Health and Substance Use Disorder</p> <p>Doctor office visit and Online Visit</p> <p>Facility visit: Facility fees</p> <p>Doctor Services</p>	<p>0% coinsurance after deductible is met</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>20% coinsurance after deductible is met</p>
<p>Outpatient Surgery</p> <p>Facility fees: Hospital</p> <p>Freestanding Surgical Center</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>

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<p>Doctor and other services</p>	<p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p>Hospital Stay (all Inpatient stays including Maternity, Mental/Behavioral Health, Substance Abuse, Infertility, Hospice and Human Organ and Tissue Transplant services):</p> <p>Facility fees (for example, room & board)</p> <p>Doctor and other services</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>Recovery & Rehabilitation</p> <p>Home health care <i>Coverage is limited to 200 visits per benefit period (80 of those visits can be Home Health Aide visits). Limit is combined In-Network and Non-Network.</i></p>	<p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p>Rehabilitation services (for example, physical/speech/occupational therapy/chiropractic):</p> <p>Office <i>Coverage for rehabilitative and habilitative physical therapy, occupational therapy, chiropractic and speech therapy combined is limited to 50 visits per benefit period. Limit is combined across professional visits and outpatient facilities. Limit is combined In- Network and Non-Network</i></p> <p>Outpatient hospital <i>Coverage for rehabilitative and habilitative physical therapy, occupational therapy, chiropractic and speech therapy combined is limited to 50 visits per benefit period. Limit is combined across professional visits and outpatient facilities. Limit is combined In- Network and Non-Network</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>

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<p>Cardiac rehabilitation</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>Skilled nursing care (in a facility) <i>Coverage for In-Network Provider and Non-Network Provider combined 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>Hospice</p>	<p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p>Durable Medical Equipment <i>Coverage for hearing aids is limited to 1 per ear every 2 years.</i></p>	<p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p>Prosthetic Devices <i>Mandatory coverage of a wig if prescribed by a licensed oncologist for a patient who suffers hair loss as a result of chemotherapy. Member cost share for prosthetic arms, legs and microprocessors is 0% coinsurance after deductible when In-Network.</i></p>	<p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>

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Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Combined with medical deductible	Combined with medical deductible
Pharmacy Out of Pocket	Combined with medical out of pocket maximum	Combined with medical out of pocket maximum
Prescription Drug Coverage <i>National Drug List</i> <i>This product has a 30-day supply is available at a Retail Pharmacy. A 90 day supply is available through Home Delivery.</i>		
Tier 1 - Typically Generic <i>Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).</i>	\$10 copay after deductible is met (\$10 retail and home delivery).	20% coinsurance after deductible (retail)
Tier 2 – Typically Preferred Brand <i>Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).</i>	\$30 copay after deductible is met (\$60 copay home delivery).	20% coinsurance after deductible (retail)
Tier 3 - Typically Non-Preferred Brand <i>Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).</i>	\$50 copay after deductible is met (\$100 retail and home delivery).	20% coinsurance after deductible (retail)

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Notes:

- The family deductible and out-of-pocket maximum are non-embedded; the deductible can be met individually or accumulatively.
- Your coinsurance, copays and deductible count toward your out of pocket amount.
- For additional information on this plan, please visit sbc.anthem.com to obtain a "Summary of Benefit Coverage".
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- If your plan includes out of network benefits and you use a non-participating provider, you are responsible for any difference between the covered expense and the actual non-participating providers charge. When receiving care from providers out of network, members may be subject to balance billing in addition to any applicable copayments, coinsurance and/or deductible. This amount does not apply to the out of network out of pocket limit.

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 (844) 682-6553.

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)

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Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'ídiilkidgo ná bohónéedzà dóó bee ahóót'í' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ąh ílinígóó. Ata' halne'ígíí la' bich'í' hadeesdzih nínizingo koj' hodiilnih (844) 682-6553.

Language Access Services:

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: (844) 682-6553.

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