

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: BOE OF NEWTOWN (Non Med Wrap): Anthem Century Preferred PPO PS CSV HRA

Your Network: Century Preferred H R A – 50% Employer Funding

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$2,000 person / \$4,000 family	\$2,000 person / \$4,000 family
Out-of-Pocket Limit	\$3,000 person / \$6,000 family	\$5,000 person / \$10,000 family
The family deductible and out-of-pocket maximum are non-embedded meaning the cost shares of all family members apply to one shared family deductible and one shared family out-of-pocket maximum. The individual deductible and individual out-of-pocket maximum only apply to individuals enrolled under single coverage.		
Preventive Care / Screening / Immunization	No charge	20% coinsurance after deductible is met
<u>Doctor Home and Office Services</u>		
Primary Care Visit	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
Routine Prenatal Care	No charge	20% coinsurance after deductible is met
Routine Postnatal Care	No charge	20% coinsurance after deductible is met
<u>Other Practitioner Visits:</u>		
Retail Health Clinic	0% coinsurance after deductible is met	20% coinsurance after deductible is met
On-line Visit <i>Includes Mental Health and Substance Abuse</i> <i>Live Health Online is the preferred telehealth solution.</i> www.livehealthonline.com	0% coinsurance after deductible is met	20% coinsurance after deductible is met

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Questions: (800) 922-6621 or visit us at www.anthem.com

CT/LG/TOWN OF NEWTOWN (Non Med Wrap): Anthem Century Preferred PPO PS CSV/5HAX/07-01-2021

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Manipulation Therapy <i>Coverage is limited to 50 visits 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 Chemo/Radiation Therapy Dialysis/Hemodialysis Prescription Drugs - <i>Dispensed in the office</i>	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>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: Office	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
Freestanding/Site of Service Radiology Center	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	20% coinsurance after deductible is met
<u>Emergency and Urgent Care</u> Urgent Care	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Emergency Room Facility Services Emergency Room Doctor and Other Services	0% coinsurance after deductible is met	Covered as In-Network
<u>Ambulance</u>	0% coinsurance after deductible is met	Covered as In-Network
<u>Outpatient Mental/Behavioral Health and Substance Abuse</u> Doctor Office Visit Facility Visit: Facility Fees Doctor Services	0% coinsurance after deductible is met	20% coinsurance after deductible is met
<u>Outpatient Surgery</u> Facility Fees: Hospital Freestanding Surgical Center	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>Doctor and Other Services:</p> <p>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>
<p><u>Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):</u></p> <p>Facility Fees</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><u>Recovery & Rehabilitation</u></p> <p>Home Health Care <i>Coverage is limited to 365 visits per benefit period.</i></p>	<p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p>Rehabilitation services:</p> <p>Office <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></p> <p>Outpatient Hospital <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></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>Cardiac rehabilitation</p> <p>Office <i>Coverage is limited to 36 visits per benefit period.</i></p> <p>Outpatient Hospital <i>Coverage is limited to 36 visits per benefit period.</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>Skilled Nursing Care (facility)</p>	<p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Hospice	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Durable Medical Equipment	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Prosthetic Devices	0% coinsurance after deductible is met	20% coinsurance after deductible is met

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	Combined with medical

Prescription Drug Coverage

National with R90

National Drug List

This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs.

Tier 1 - Typically Generic <i>30 day supply (retail pharmacy). 90 day supply (home delivery).</i>	\$10 copay per prescription after deductible is met (retail) and \$20 copay per prescription after deductible is met (home delivery)	20% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand <i>30 day supply (retail pharmacy). 90 day supply (home delivery).</i>	\$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 <i>30 day supply (retail pharmacy). 90 day supply (home delivery).</i>	\$50 copay per prescription after deductible is met (retail) and \$100 copay per prescription after	20% coinsurance after deductible is met (retail) and Not covered (home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
	deductible is met (home delivery)	

Notes:

- Your copays, coinsurance and deductible count toward your out of pocket amount.
- 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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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 (800) 922-6621

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 (800) 922-6621.

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՝ (800) 922-6621:

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(800) 922-6621。

Farsi (فارسی): 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 (800) 922-6621 تماس بگیرید.

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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 (800) 922-6621.

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 (800) 922-6621.

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、(800) 922-6621 にお電話ください。

Language Access Services:

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(800) 922-6621로 문의하십시오.

Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'idílkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bááh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih nínizingo kojí' hodiílnih (800) 922-6621.

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: (800) 922-6621.

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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. (800) 922-6621.

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