Your summary of benefits

Anthem®

Anthem® Blue Cross and Blue Shield

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

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	$2,000 person / $4,000 family	$2,000 person / $4,000 family
Overall Out-of-Pocket Limit	$3,000 person / $6,000 family	$5,000 person / $10,000 family
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. Your copays, coinsurance and deductible count toward your out of pocket limit(s). In-Network and Non-Network deductibles are combined and accumulate toward each other; however In-Network and Non-Network out-of-pocket limit amounts accumulate separately and do not accumulate toward each other.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Virtual Visits from online provider LiveHealth Online *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.*		
Primary Care (PCP) and Mental Health and Substance Abuse Care *virtual and office*	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Specialist Care *virtual and office*	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	No charge	20% coinsurance after deductible is met
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	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
Manipulation Therapy *Coverage for rehabilitative and habilitative physical therapy, occupational therapy, speech therapy, and manipulative treatment is limited to 50 visits combined per benefit period.*	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
Other Services in an Office		
Allergy Testing	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Surgery	0% 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 *per IRS guidelines*	No charge	20% coinsurance after deductible is met
Diagnostic Services **Lab**		
Office	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Freestanding/Site of Service Lab	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
X-Ray		
Office	0% coinsurance after deductible is met	20% coinsurance after deductible is met
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
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Freestanding/Site of Service Radiology Center	0% coinsurance after	20% coinsurance after

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

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with Non-Network medical deductible

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***		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below) 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.* **Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.*		
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
This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.		
Child Vision exam *Limited to 1 exam per benefit period.*	No charge	20% coinsurance after deductible is met
Adult Vision exam *Limited to 1 exam per benefit period.*	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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