

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: TOWN OF NEWTOWN (Non Med Wrap): Anthem Century Preferred PPO HRA 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>Other Practitioner Visits</p> <p>Routine Maternity Care (Prenatal and Postnatal)</p> <p>Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i></p>	<p>No charge</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>

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans, Inc. Independent licensee of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

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.

Intentionally Left Blank

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 (888) 224-4896

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 (888) 224-4896.

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՝ (888) 224-4896:

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(888) 224-4896。

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 (888) 224-4896 تماس بگیرید.

French (Français): Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (888) 224-4896.

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 (888) 224-4896.

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 (888) 224-4896.

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、(888) 224-4896 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(888) 224-4896로 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 báháh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih nínizingo koj' hodiílnih (888) 224-4896.

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: (888) 224-4896.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਬਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (888) 224-4896 ਤੇ ਕਾਲ ਕਰੋ।

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. (888) 224-4896.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (888) 224-4896.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (888) 224-4896.

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (888) 224-4896.

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.