Your summary of benefits

Anthem BlueCross BlueShield

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

Your Plan: Anthem Century Preferred CGHSA4351

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 *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$2,000 person / $4,000 family	
Out-of-Pocket Limit *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.*	$3,000 person / $6,000 family	$5,000 person / $10,000 family
Preventive care/screening/immunization *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.*	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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Routine Prenatal Care	No Charge	20% coinsurance after deductible is met
Routine Postnatal Care	No Charge	20% coinsurance after deductible is met
Other practitioner visits:		
Retail health clinic	0% coinsurance after deductible is met	20% coinsurance after deductible is met
On-line Medical Visit *Live Health Online is* the *preferred telehealth solutions (www.livehealthonline.com)*	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Acupuncture *Covered*	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
Chemo/radiation therapy	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Dialysis/Hemodialysis	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Prescription drugs *For the drugs itself dispensed in the office thru infusion/injection.*	0% coinsurance after deductible is met	20% coinsurance after deductible is met

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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: *Imaging services include MRI, MRA, CAT, CTA, PET, and SPECT scans*		
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

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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 Transportation	0% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder		
Doctor office visit and Online Visit	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Facility visit: 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
Freestanding Surgical Center	0% coinsurance after deductible is met	20% coinsurance after deductible is met

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Doctor and other services	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Hospital Stay (all Inpatient stays including Maternity, Mental/Behavioral Health, Substance Abuse, Infertility, Hospice and Human Organ and Tissue Transplant services):		
Facility fees (for example, room & board)	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Doctor and other services	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Recovery & Rehabilitation		
Home health care *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.*	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy/chiropractic):		
Office *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*	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient hospital *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*	0% coinsurance after deductible is met	20% coinsurance after deductible is met

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Cardiac rehabilitation		
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
Skilled nursing care (in a facility) *Coverage for In-Network Provider and Non-Network Provider combined is limited to 120 days per benefit period.*	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Hospice	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Durable Medical Equipment *Coverage for hearing aids is limited to 1 per ear every 2 years.*	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Prosthetic Devices *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.*	0% coinsurance after deductible is met	20% coinsurance after deductible is met

Your summary of benefits

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 *National Drug List* *This product has a 30-day supply is available at a Retail Pharmacy. A 90 day supply is available through Home Delivery.*		
Tier 1 - Typically Generic *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).*	$10 copay after deductible is met ($10 retail and home delivery).	20% coinsurance after deductible (retail)
Tier 2 – Typically Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).*	$30 copay after deductible is met ($60 copay home delivery).	20% coinsurance after deductible (retail)
Tier 3 - Typically Non-Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).*	$50 copayafter deductible is met ($100 retail and home delivery).	20% coinsurance after deductible (retail)

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.

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