Newtown BOE: Century Preferred $30/$40/$300/$75/$200/$300

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 07/01/2016 – 06/30/2017

Coverage for: Individual + Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at https://eoc.anthem.com/eocdps/aso or by calling (800) 922-6621.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0** individual / **$0** 2-member family/ **$0** 3+member family for In-Network Providers. **$600** individual / **$900** 2-member family/ **$1,200** 3+member family for Out-of-Network Providers. In-Network Providers and Non-Network Providers deductibles are separate and do not count towards each other.	You must pay all costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes; **$50** for Out-of-Network Providers Home Health Care. There are no other specific **deductibles.**	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes; **$6,600** individual / **$13,200** 2-member family/ **$13,200** 3+member family for In-Network Providers. **$2,000** individual / **$4,000** 2-member family/ **$6,000** 3+member family for Out-of-Network Providers. In-Network Providers and Non-Network Providers Out of Pocket are separate and do not count towards each other.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.

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

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call (800) 922-6621 to request a copy.

Important Questions	Answers	Why this Matters:
What is not included in the out–of–pocket limit?	Premiums, Balance-Billed charges, and Health Care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes, Century Preferred. For a list of In-Network providers, see www.anthem.com or call **(800) 922-6621**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No; you do not need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 8. See your policy or plan document for additional information about **excluded services.**

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **In-Network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay per visit	20% coinsurance	--------none--------
	Specialist visit	$40 copay per visit	20% coinsurance	--------none--------
	Other practitioner office visit	Chiropractor $30 copay per visit Acupuncture $40 copay per visit	Chiropractor 20% coinsurance Acupuncture 20% coinsurance	Chiropractor Coverage for In-Network Providers and Non-Network Providers combined is limited to 50 visits per benefit period including Physical Therapy, Occupational Therapy and Speech Therapy.
	Preventive care/screening/immunization	No cost share	20% coinsurance	Hearing screening: $30 copay per visit for In-Network Providers.
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office No cost share X-Ray – Office $30 copay per visit	Lab – Office 20% coinsurance X-Ray – Office 20% coinsurance	Lab – Office --------none-------- X-Ray – Office Costs may vary by site of service.
	Imaging (CT/PET scans, MRIs)	$50 copay per visit	20% coinsurance	Coverage for In-Network Providers is limited to $250 maximum per benefit period.

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.anthem.com/pharmacyinformation/	Tier 1 - Generic drugs	$10 copay per prescription (retail only) and $20 copay per prescription (home delivery only)	20% of the In-Network allowance, plus the difference between anthem blue cross and blue shield's payment and the pharmacist's actual charge	Covers up to a 30 day supply (retail pharmacy) Covers up to a 30 day to 90 day supply (home delivery) Coverage for In-Network Providers and Non-Network Providers combined is limited to $4,000 maximum per benefit period. When you purchase a generic drug at a participating pharmacy, you'll only be responsible for a tier 1 copayment.
	Tier 2 - Listed brand-name drugs	$30 copay per prescription (retail only) and $60 copay per prescription (home delivery only)	20% of the In-Network allowance, plus the difference between anthem blue cross and blue shield's payment and the pharmacist's actual charge	Covers up to a 30 day supply (retail pharmacy) Covers up to a 30 day to 90 day supply (home delivery) Coverage for In-Network Providers and Non-Network Providers combined is limited to $4,000 maximum per benefit period. When a generic equivalent is available and you obtain a listed or non-listed brand-name drug, you will be responsible for the applicable tier copayment plus the difference in cost between the generic and listed or non-listed brand-name drug.
	Tier 3 - Non-listed brand-name drugs	$50 copay per prescription (retail only) and $100 copay per prescription (home delivery only)	20% of the In-Network allowance, plus the difference between anthem blue cross and blue shield's payment and the pharmacist's actual charge	Covers up to a 30 day supply (retail pharmacy) Covers up to a 30 day to 90 day supply (home delivery) Coverage for In-Network Providers and Non-Network Providers combined is limited to $4,000 maximum per benefit period. When a generic equivalent is available and you obtain a listed or non-listed brand-name drug,

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
				you will be responsible for the applicable tier copayment plus the difference in cost between the generic and listed or non-listed brand-name drug.
	Tier 4 - Typically Specialty Drugs	Not Applicable	Not Applicable	--------none--------
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$300 copay per visit	20% coinsurance	--------none--------
	Physician/surgeon fees	$30 copay per visit	20% coinsurance	Costs may vary by site of service.
If you need immediate medical attention	Emergency room services	$125 copay per visit	Covered as In-Network	Copay waived if admitted.
	Emergency medical transportation	No cost share	Covered as In-Network	--------none--------
	Urgent care	$75 copay per visit	Not covered	Walk-in-centers: $30 copay per visit for In-Network Providers and 20% coinsurance for Non-Network Providers.
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 copay per day up to $900 copay per admission	20% coinsurance	Copay is waived if readmitted within 30 days for same diagnosis. Prior Authorization is required
	Physician/surgeon fee	$30 copay per visit	20% coinsurance	Costs may vary by site of service.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit $30 copay per visit Mental/Behavioral Health Facility Visit - Facility Charges $30 copay per visit	Mental/Behavioral Health Office Visit 20% coinsurance Mental/Behavioral Health Facility Visit - Facility Charges 20% coinsurance	Mental/Behavioral Health Office Visit --------none-------- Mental/Behavioral Health Facility Visit - Facility Charges --------none--------
	Mental/Behavioral health inpatient services	$300 copay per day up to $900 copay per admission	20% coinsurance	Copay is waived if readmitted within 30 days for same diagnosis. Prior Authorization is required
	Substance use disorder outpatient services	Substance Use Office Visit $30 copay per visit Substance Use Facility	Substance Use Office Visit 20% coinsurance Substance Use Facility	Substance Use Office Visit --------none-------- Substance Use Facility Visit - Facility Charges

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
		Visit - Facility Charges $30 copay per visit	Visit - Facility Charges 20% coinsurance	--------none--------
	Substance use disorder inpatient services	$300 copay per day up to $900 copay per admission	20% coinsurance	Copay is waived if readmitted within 30 days for same diagnosis. Prior Authorization is required
If you are pregnant	Prenatal and postnatal care	$40 copay per visit	20% coinsurance	Copay applies to initial visit. There may be other levels of cost share that are contingent on how services are provided.
	Delivery and all inpatient services	$300 copay per day up to $900 copay per admission	20% coinsurance	Copay is waived if readmitted within 30 days for same diagnosis. Prior Authorization is required
If you need help recovering or have other special health needs	Home health care	No cost share	20% coinsurance	Coverage for In-Network Providers and Non-Network Providers combined is limited to 300 visits per benefit period including 80 home health aides.
	Rehabilitation services	$30 copay per visit	20% coinsurance	Coverage for In-Network Providers and Non-Network Providers combined is limited to 50 visits per benefit period for Physical, Occupational and Speech Therapy including Chiropractic care.
	Habilitation services	$30 copay per visit	20% coinsurance	Habilitation visits count towards your rehabilitation limit.
	Skilled nursing care	$300 copay per day up to $900 copay per admission	20% coinsurance	Coverage for In-Network Providers and Non-Network Providers combined is limited to 120 days limit per benefit period. Prior Authorization is required
	Durable medical equipment	No cost share	20% coinsurance	--------none--------
	Hospice service	No cost share	No cost share	--------none--------

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	$30 copay per visit	20% coinsurance	Coverage for In-Network Providers and Non-Network Providers combined is limited to 1 exam per benefit period.
	Glasses	Not covered	Not covered	--------none--------
	Dental check-up	Not covered	Not covered	--------none--------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (adult)
- Long- term care
- Routine foot care unless you have been diagnosed with diabetes.
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Chiropractic care
- Hearing aids
- Infertility treatment
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide
- Routine eye care (adult) Coverage is limited to 1 exam per benefit period.
- Private Duty Nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at (800) 922-6621. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

ATTN: Grievances and Appeals
P.O. Box 1038
North Haven, CT 06473-4201

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoolwol íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'alníhí ya sidáhí bich'į naabídíilkiid. Eí doo biigha daago ni ba'nija'go ho'aalagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About These Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,980
- **Patient pays** $560

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$410
Coinsurance	$0
Limits or exclusions	$150
Total	$560

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,620
- **Patient pays** $780

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$700
Coinsurance	$0
Limits or exclusions	$80
Total	$780

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co payments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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

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