The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit http://www.osc.ct.gov/benefits/docs/MedicalPlanDoceff1012016updt9132016.pdf. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copay, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at http://www.cciio.cms.gov or call Anthem Blue Cross and Blue Shield at 800-922-2232 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: **$350**/individual; **$1,400**/family. **Waived for Health Enhancement Program (HEP) Members and pre-October 2, 2011 retirees** Out-of-network: **$300**/individual; **$900**/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. Once you or a family member meets the individual deductible amount, the plan begins to pay for you or that family member. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network primary care and specialist office visits, in-network preventive care, prescription drugs, emergency room care, in-network urgent care, in-network mental health and substance abuse outpatient services, and in-network eye exams are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copay or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical: In-network: **$2,000**/individual; **$4,000**/family; Out-of-network: **$2,300**/individual; **$4,900**/family Prescription drugs: **$4,600**/individual; **$9,200**/family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties for failure to obtain prior authorization for services and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.anthem.com/statect or call 800-922-2232 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred In-Network Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge. Deductible does not apply.	$15 copay/visit Pre-1999 Retirees: $5 copay/visit Deductible does not apply.	20% coinsurance	None.
	Specialist visit	No charge. Deductible does not apply.	$15 copay/visit Pre-1999 Retirees: $5 copay/visit Deductible does not apply.	20% coinsurance	
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	No charge. Deductible does not apply.	20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge.	20% coinsurance	40% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	No charge.	20% coinsurance	40% coinsurance	Prior authorization required to avoid penalty of lesser of $500 or 20% of cost of services.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred In-Network Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.osc.ct.gov/benefits/pharmacy.htm	Generic drugs	Preferred generic - Non-Maintenance: $5 copay/fill retail; Preferred generic - Maintenance: $5 copay/fill mail order or Maintenance drug pharmacy. Non-preferred generic: Non-Maintenance: $10 copay/fill retail; Non-preferred - Maintenance: $10 copay/fill mail order or Maintenance drug pharmacy. Retired July 2, 2009 – October 1, 2011: Non-Maintenance: $5 copay/fill retail; Maintenance: $0 copay/initial fill mail order/maintenance drug pharmacy. Pre-July 1, 2009 retirees: Non-maintenance: $3 copay/fill retail; Maintenance: $0 copay/initial fill mail order/Maintenance drug pharmacy		20% coinsurance for non-participating pharmacy.	Deductible will not apply to prescription drug coverage. No charge for FDA-approved contraceptives (or brand name contraceptives if a generic is medically inappropriate).See details of your coverage for slightly adjusted copays for persons retired between July 1, 2009 and October 1, 2011, and persons retired after October 1, 2011. Check the details at http://www.osc.ct.gov/benefits/pharmacy.htm Maintenance drugs must be filled by mail order or maintenance drug pharmacy after first initial retail fill. Penalty may apply if brand name drug is requested when a generic is available. Prescription drugs purchased at a retail pharmacy are limited to a maximum of a 30-day supply; prescription drugs purchased through mail order or maintenance drug pharmacy are limited to a maximum of a 90-day supply. For some prescription drugs, prior authorization may be required. Prescription drug coverage is separately administered.
	Preferred brand drugs	Non-Maintenance: $25 copay/fill retail; Maintenance: $25 copay/initial fill mail order/Maintenance drug pharmacy. Retired July 2, 2009 – October 1, 2011: Non-Maintenance: $10 copay/fill retail; Maintenance: $25 copay/initial fill; $25 copay/fill mail order/ Maintenance drug pharmacy. Pre-July 1, 2009 retirees: Non-Maintenance: $6 copay/fill retail; Maintenance: $0 copay/initial fill; $0 copay/fill mail order/Maintenance drug pharmacy.		20% coinsurance for non-participating pharmacy.	
	Non-preferred brand drugs	Non-Maintenance: $40 copay/fill retail; Maintenance: $40 copay/initial fill mail order/Maintenance drug pharmacy. Retired July 2, 2009 – October 1, 2011: Non-Maintenance: $25 copay/fill retail; Maintenance: $0 copay/initial fill mail order/ maintenance drug pharmacy. Pre-July 1, 2009 retirees: Non-Maintenance: $6 copay/fill retail; Maintenance: $0 copay/initial fill mail order/maintenance drug pharmacy		20% coinsurance for non-participating pharmacy.	
	Specialty drugs	No charge for specialty drugs if enrolled in PrudentRx program. Same as non-preferred brand drugs if not enrolled in PrudentRx program.		Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred In-Network Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge		20% coinsurance	Prior authorization required to avoid penalty of lesser of $500 or 20% of cost of services.
	Physician/surgeon fees	No charge		20% coinsurance	
If you need immediate medical attention	Emergency room care	$250 copay/visit. Retired October 2, 2011 – October 1, 2017: $35 copay/visit Pre-October 2, 2011 Retirees: No charge Deductible does not apply.		$250 copay/visit Retired October 2, 2011 – October 1, 2017: $35 copay/visit Pre-October 2, 2011 Retirees: No charge Deductible does not apply.	Copay waived if admitted or if no reasonable medical alternative.
	Emergency medical transportation	No charge		No charge	None.
	Urgent care	$15 copay/visit Pre-1999 Retiree: $5 copay/visit Deductible does not apply.		20% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge		20% coinsurance	Prior authorization required to avoid penalty of lesser of $500 or 20% of cost of services. No coverage in excess of cost of a semi-private room unless medically necessary.
	Physician/surgeon fees	No charge		20% coinsurance	Prior authorization required to avoid penalty of lesser of $500 or 20% of cost of services.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred In-Network Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/visit Pre-1999 Retirees: $5 copay/visit Deductible does not apply.		20% coinsurance	None.
	Inpatient services	No charge		20% coinsurance	Prior authorization required to avoid penalty of lesser of $500 or 20% of cost of services.
If you are pregnant	Office visits	$15 copay/first visit only Pre-1999 Retiree: $5 copay/initial visit only Deductible does not apply.		20% coinsurance	Cost sharing does not apply for preventive care services. Depending on the type of services, a copay, coinsurance, or deductible may apply. Maternity care may include tests and services described within another section (i.e., ultrasound).
	Childbirth/delivery professional services	No charge		20% coinsurance	Prior authorization required to avoid penalty of lesser of $500 or 20% of cost of services.
	Childbirth/delivery facility services	No charge		20% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge		20% coinsurance	Limit: 200 visits/calendar year.
	Rehabilitation services	No charge		20% coinsurance	Prior authorization required (except for pre-1999 retirees) to avoid penalty of lesser of $500 or 20% of covered services. In-network speech therapy limit: 30 visits/calendar year. Limit does not apply to treatment resulting from autism, stroke, tumor removal, injury or congenital anomalies of oropharynx. Out-of-network physical, occupational, chiropractic, speech & autism therapy limit: 30 visits/condition/calendar year.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred In-Network Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
	Habilitation services	No charge		20% coinsurance	None.
	Skilled nursing care	No charge		20% coinsurance	Out-of-network services limit: 60 days/calendar year. Prior authorization required to avoid penalty of lesser of $500 or 20% of cost of services.
	Durable medical equipment	No charge		20% coinsurance	Prior authorization required to avoid penalty of lesser of $500 or 20% of cost of services.
	Hospice services	No charge		20% coinsurance	Out-of-network in-home hospice limit: 200 visits/calendar year. Out-of-network inpatient hospice limit: 60 days/calendar year. Prior authorization required for inpatient services to avoid penalty of lesser of $500 or 20% of cost of services.
If your child needs dental or eye care	Children's eye exam	$15 copay/visit Deductible does not apply.		50% coinsurance	Limit: 1 visit/calendar year. Copay waived for HEP members in alternate years.
	Children's glasses	Not covered		Not covered	You must pay 100% of this service, even in-network.
	Children's dental check-up	Not covered		Not covered	You must pay 100% of this service, even in-network.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Children's glasses
- Cosmetic surgery
- Dental care (adult and child)
- Long-term care
- Non-emergency care outside the U.S. (urgent care covered).
- Routine foot care
- Weight loss programs (except as required by law)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (covered only if medically necessary for osteoarthritis or nausea and vomiting associated with surgery, chemotherapy or pregnancy) • Bariatric surgery (prior authorization required)	• Chiropractic care (limit: 30 out-of-network visits/year) • Hearing aid (limit: 1 set per 36 month period; prior authorization may be required for bone-anchored devices)	• Infertility treatment (prior authorization required) • Private duty nursing (prior authorization required) • Routine eye care (Adult) (limit: 1 exam/year)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 877-267-2323 x61565 or http://www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

Anthem Blue Cross and Blue Shield
108 Leigus Road
Wallingford, CT 06492
800-922-2232

CVS/Caremark
Prescription Claim Appeals MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax: 866-443-1172

Additionally, a consumer assistance program can help you file your appeal. Contact the Connecticut Office of the Healthcare Advocate at 866-466-4446.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Para obtener asistencia en Español, llame al 800-922-2232.
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-922-2232.
如果需要中文的帮助，请拨打这个号码 800-922-2232.
Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-922-2232.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copays and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$350**
Specialist copayment	**$15**
Hospital (facility)	**$0**
Other	**$0**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$350
Copays	$25
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$435**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$350**
Specialist copayment	**$15**
Hospital (facility)	**$0**
Other	**$0**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$120
Copays	$190
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$310**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$350**
Specialist copayment	**$15**
Hospital (facility)	**$0**
Other	**$0**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$350
Copays	$320
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$670**

NOTE: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your cost. For more information about the wellness program, please visit http://www.osc.ct.gov/benefits.htm.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.