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 www.anthem.com or by calling 1-888-224-4896.

Health Savings Account Contribution: **$3,300** Individual/**$6,550** Family

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,500** individual / **$3,000** family	You must pay all the 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 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	For in-network providers **$1,500** individual / **$3,000** family For out-of-network providers **$3,000** individual / **$6,000** family	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.
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 2 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. For a list of **in-network providers**, see www.anthem.com or call 1-800-922-6621	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 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	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 5. 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	No Charge, after Deductible	20% Coinsurance, after Deductible	——————none——————
	Specialist visit	No Charge, after Deductible	20% Coinsurance, after Deductible	——————none——————
	Other practitioner office visit	No Charge, after Deductible	20% Coinsurance, after Deductible	
	Preventive care/screening/immunization	No Charge, Deductible is waived	20% Coinsurance, after Deductible	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	No Charge, after Deductible	20% Coinsurance, after Deductible	——————none——————
	Imaging (CT/PET scans, MRIs)	No Charge, after Deductible	20% Coinsurance, after Deductible	——————none——————
If you need drugs to treat your illness or condition More information about **prescription**	Tier 1 drugs	No Charge, after Deductible	20% Coinsurance, after Deductible	Retail is a 30 day supply. Mail order is a 90 day supply.
	Tier 2 drugs	No Charge, after Deductible	20% Coinsurance, after Deductible	

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
drug coverage is available at www.anthem.com	Tier 3 drugs	No Charge, after Deductible	20% Coinsurance, after Deductible	
	Specialty drugs	No Charge, after Deductible	20% Coinsurance, after Deductible	
If you have outpatient surgery	Facility fee (In a general hospital or ambulatory surgery center)	No Charge, after Deductible	20% Coinsurance, after Deductible	——————none——————
	Physician/surgeon fees	No Charge, after Deductible	20% Coinsurance, after Deductible	——————none——————
If you need immediate medical attention	Emergency room services	No Charge, after Deductible	No Charge, after Deductible	——————none——————
	Emergency medical transportation	No Charge, after Deductible	No Charge, after Deductible	——————none——————
	Urgent care	No Charge, after Deductible	20% Coinsurance, after Deductible	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge, after Deductible	20% Coinsurance, after Deductible	Inpatient hospitalizations require authorizations.
	Physician/surgeon fee	No Charge, after Deductible	20% Coinsurance, after Deductible	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No Charge, after Deductible	20% Coinsurance, after Deductible	Prior authorization is required.
	Mental/Behavioral health inpatient services	No Charge, after Deductible	20% Coinsurance, after Deductible	Prior authorization is required.
	Substance Abuse outpatient services	No Charge, after Deductible	20% Coinsurance, after Deductible	Prior authorization is required.
	Substance Abuse inpatient services	No Charge, after Deductible	20% Coinsurance, after Deductible	Prior authorization is required.
If you are pregnant	Prenatal and postnatal care	No Charge, after Deductible	20% Coinsurance, after Deductible	——————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
	Delivery and all inpatient services	No Charge, after Deductible	20% Coinsurance, after Deductible	Inpatient hospitalizations require authorizations.
If you need help recovering or have other special health needs	Home health care	No Charge, after Deductible	20% Coinsurance, after Deductible	Limited to 100 visits per member per calendar year.
	Rehabilitation services	No Charge, after Deductible	20% Coinsurance, after Deductible	Physical Therapy/Occupational Therapy/Speech Therapy combined limit of 60 visits per member per calendar year. Prior authorization required after the first visit for Physical Therapy and Occupational Therapy. Chiropractic services limited to 12 visits per member per calendar year.
	Habilitation services	No Charge, after Deductible	20% Coinsurance, after Deductible	All rehabilitation and habilitation visits count toward your rehabilitation visit limit.
	Skilled nursing care	No Charge, after Deductible	20% Coinsurance, after Deductible	Prior authorization is required. Limited to 100 days per member per calendar year.
	Durable medical equipment	No Charge, after Deductible	20% Coinsurance, after Deductible	——————none——————
	Hospice service	No Charge, after Deductible	20% Coinsurance, after Deductible	Prior authorization is required.
If your child needs dental or eye care	Eye exam	**$20** copay	20% Coinsurance, after Deductible	1 exam every 12 months
	Glasses	Not Covered	Not Covered	
	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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Long-term care
- Routine foot care
- 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.)

- Chiropractic care (limits apply)
- Hearing aids (restrictions apply)
- Non-emergency care when traveling outside the U.S.
- Coverage provided outside the United States. See www.BCBS.com/bluecardworldwide
- Routine eye care
- Infertility treatment (restrictions apply)

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 1-888-401-3539. 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:

Anthem Blue Cross Blue Shield
108 Leigus Road
Wallingford, CT 06492

Department of Labor's Employee Benefits Security Administration
1-866-444-EBSA (3272)
www.dol.gov/ebsa/healthreform

Connecticut insurance Department
153 Market Street, 7th Floor
Hartford, CT 06103
Main Phone Number: (860) 297-3800 or 1 (800) 203-3447
Consumer Helpline: (860) 297-3900 or 1 (800) 203-3447

Additionally, a consumer assistance program can help you file your appeal. Contact:

Connecticut Office of the Healthcare Advocate
P.O. Box 1543
Hartford, CT 06144
(866) 466-4446
www.ct.gov/oha
healthcare.advocate@ct.gov

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:

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.

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。

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.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíigo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíiłkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí 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.

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
(Participating Provider - normal delivery- family contract)

- **Amount owed to providers:** $15,600
- **Plan pays** $13,600
- **Patient pays** $2,500

Sample care costs:

Hospital charges (mother)- 3 days	$7,800
Routine obstetric care	$4,100
Hospital charges (baby)	$1,900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Total	**$15,600**

Patient pays:

Deductibles	$2,500
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$2,500**

Managing type 2 diabetes
(Participating Provider -maintenance of a well-controlled condition- family contract)

- **Amount owed to providers:** $6,300
- **Plan pays** $2,300
- **Patient pays** $2,500

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$2,300
Office Visits	$700
Xrays	$300
Laboratory tests	$100
Total	**$6,300**

Patient pays:

Deductibles	$2,500
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$2,500**

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**, **copayments**, 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.