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 1-800-922-6621.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For in-network providers **Deductible is not applicable in-network** For out-of-network providers **$200** individual / **$400** 2–member family / **$500** 3+ member family Doesn't apply to in-network preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered out-of-network 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: **$6,350** individual / **$12,700** 2–member family / **$12,700** 3+ member family For out-of-network providers: **$1,000** individual / **$2,000** 2–member family / **$2,500** 3+ member family	The **out-of-pocket limit** is the most you could pay during a policy period 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 **preferred 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 6. 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 30% would be $300. 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	$25 copay/visit	20% coinsurance, after deductible	——————none——————
	Specialist visit	$40 copay/visit	20% coinsurance, after deductible	——————none——————
	Other practitioner office visit	No Charge	20% coinsurance, after deductible	50 combined PT/OT/ST/Chiro per member per calendar year.
	Preventive care/screening/immunization	No Charge	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
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% coinsurance, after deductible	
	Imaging (CT/PET scans, MRIs)	No Charge	20% coinsurance, after deductible	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.anthem.com.	Generic drugs	$15 copay/prescription $30 copay/prescription for mail-order	Members who use non-participating pharmacies will pay 20% of the in-network allowance, plus the difference between Anthem Blue Cross and Blue Shield's payment and the pharmacist's actual charge.	Unlimited per member per calendar year.
	Preferred brand drugs	$25 copay/prescription $50 copay/prescription for mail-order		
	Non-preferred brand drugs	$40 copay/prescription $80 copay/prescription for mail-order		
	Specialty drugs	$40 copay/prescription $80 copay/prescription for mail-order		
If you have outpatient surgery	Facility fee – General Hospital	$100 copay/visit	20% coinsurance, after deductible	——————none——————
	Physician/surgeon fees	No Charge	20% coinsurance, after deductible	——————none——————
If you need immediate medical attention	Emergency room services	$100 copay/visit	$100 copay/visit	Copay waived if admitted
	Emergency medical transportation	No Charge	No Charge	——————none——————
	Urgent care	$25 copay/visit	Not Covered	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 Copay per day/$500 Copay per stay/ $500 maximum per year	20% coinsurance, after deductible	Inpatient hospitalizations require authorizations.
	Physician/surgeon fee	No Charge	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
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copay/visit	20% coinsurance, after deductible	Prior authorization is required.
	Mental/Behavioral health inpatient services	$100 Copay per day/$500 Copay per stay/ $500 maximum per year	20% coinsurance, after deductible	Prior authorization is required.
	Substance Abuse outpatient services	$25 copay/visit	20% coinsurance, after deductible	Prior authorization is required.
	Substance Abuse inpatient services	$100 Copay per day/$500 Copay per stay/ $500 maximum per year	20% coinsurance, after deductible	Prior authorization is required.
If you are pregnant	Prenatal and postnatal care	$40 copay/visit	20% coinsurance, after deductible	Initial visit only is subject to in-network copay. No charge, thereafter.
	Delivery and all inpatient services	$100 Copay per day/$500 Copay per stay/ $500 maximum per year	20% coinsurance, after deductible	Prior authorization is required.
If you need help recovering or have other special health needs	Home health care	No Charge	$50 deductible applies and 20% coinsurance	Unlimited per member per calendar year.
	Rehabilitation services	No Charge	20% coinsurance, after deductible	50 combined PT/OT/ST/Chiro per member per calendar year.
	Habilitation services	No Charge	20% coinsurance, after deductible	All rehabilitation and habilitation visits count toward your rehabilitation visit limit.
	Skilled nursing care	$100 Copay per day/$500 Copay per stay/ $500 maximum per year	20% coinsurance, after deductible	Prior authorization is required. Skilled nursing facility services limited to 120 days per member per calendar year.

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
	Durable medical equipment	No Charge	20% coinsurance, after deductible	For a complete list of exclusions and limitations, please reference your Certificate of Coverage.
	Hospice service	No Charge	20% coinsurance, after deductible	Prior authorization is required.
If your chil d needs dental or eye care	Eye exam (routine or medical)	No Charge	20% Coinsurance	1 exam every 2 years
	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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Weight loss programs
- Long-term care
- Routine foot care
- Acupuncture

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
-
- Infertility treatment (restrictions apply)
- Private-duty nursing- (restrictions apply)
- Routine eye care

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 Appeals
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

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
(In-network Provider- 2 day normal delivery)

- **Amount owed to providers:** $15,540
- **Plan pays** $15,010
- **Patient pays** $500

Sample care costs:

Hospital charges (mother)	$10,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$15,540**

Patient pays:

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

Managing type 2 diabetes
(In-network Provider -maintenance of a well-controlled condition)

- **Amount owed to providers:** $1,600
- **Plan pays** $1,510
- **Patient pays** $150

Sample care costs:

Prescriptions	$500
Medical Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Total	**$1,600**

Patient pays:

Deductibles	$0
Copays	$150
Coinsurance	$0
Limits or exclusions	$0
Total	**$150**

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.