

 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 [www.osc.ct.gov/benefits/docs/MedicalPlanDoceff1012016updt9132016.pdf](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 800-922-2232 (Anthem) or 800-385-9055 (Oxford) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	In-network: \$350/individual; \$1,400/family. Waived for HEP Members and pre-October 2, 2011 retirees Out-of-network: \$300/individual; \$900/family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> and <u>prescription drugs</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copay</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Medical: \$2,000/individual; \$4,000/family <u>Prescription drugs</u> : \$4,600/individual; \$9,200/family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Out-of-network <u>deductible</u> and <u>cost sharing</u> , <u>premiums</u> , <u>balance-billing</u> charges, penalties for failure to obtain prior authorization for services and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.anthem.com/staect">www.anthem.com/staect</a> or call 800-922-2232 or <a href="http://stateofct.welcometouhc.com/home">http://stateofct.welcometouhc.com/home</a> or call 800-385-9055 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .
--	-----	--

All copay 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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$15 <u>copay</u> /visit Pre-1999 Retirees: \$5 <u>copay</u> /visit	20% <u>coinsurance</u>	None.
	<u>Specialist</u> visit	\$15 <u>copay</u> /visit Pre-1999 Retirees: \$5 <u>copay</u> /visit	20% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No charge. <u>Deductible</u> will not apply.	20% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	20% <u>coinsurance</u>	None.
	Imaging (CT/PET scans, MRIs)	No charge	20% <u>coinsurance</u>	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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p><b>If you need drugs to treat your illness or condition</b>            More information about <u>prescription drug coverage</u> is available at <a href="http://www.osc.ct.gov/benefits/pharmacy.htm">http://www.osc.ct.gov/benefits/pharmacy.htm</a></p>	Generic drugs	\$5 <u>copay</u> /retail; maintenance drug: \$5 <u>copay</u> /initial fill; \$0 <u>copay</u> /mail order or maintenance drug pharmacy Pre-July 1, 2009 retirees: \$3 <u>copay</u> /retail; maintenance drug: \$0 <u>copay</u> /initial fill; \$0 <u>copay</u> mail order or maintenance drug pharmacy	20% <u>coinsurance</u> for non-participating pharmacy.	<p><u>Deductible</u> will not apply to <u>prescription drug coverage</u>. No charge for FDA-approved contraceptives (or brand name contraceptives if a generic is medically inappropriate). See details of your coverage for slightly adjusted <u>copays</u> for persons retired between July 1, 2009 and October 1, 2011, and persons retired after October 1, 2011. Check the details at <a href="http://www.osc.ct.gov/benefits/pharmacy.htm">http://www.osc.ct.gov/benefits/pharmacy.htm</a>            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. <u>Prescription drugs</u> purchased at a retail pharmacy are limited to a maximum of a 30-day supply; <u>prescription drugs</u> purchased through mail order or maintenance drug pharmacy are limited to a maximum of a 90-day supply.</p> <p>For some <u>prescription drugs</u>, prior authorization may be required. <u>Prescription drug coverage</u> is separately administered.</p>
	Preferred brand drugs	\$20 <u>copay</u> /retail; maintenance drug: \$10 <u>copay</u> /initial fill; \$5 <u>copay</u> /mail order or maintenance drug pharmacy Pre-July 1, 2009 retirees: \$6 <u>copay</u> /retail; maintenance drug: \$0 <u>copay</u> /initial fill; \$0 <u>copay</u> /mail order or maintenance drug pharmacy	20% <u>coinsurance</u> for non-participating pharmacy.	
	Non-preferred brand drugs	\$35 <u>copay</u> /retail; maintenance drug: \$25 <u>copay</u> /initial fill; \$12.50 <u>copay</u> /mail order or maintenance drug pharmacy Pre-July 1, 2009 retirees: \$6 <u>copay</u> /retail; maintenance drug: \$0 <u>copay</u> /initial fill; \$0 <u>copay</u> mail order or maintenance drug pharmacy	20% <u>coinsurance</u> for non-participating pharmacy.	
	<u>Specialty drugs</u>	Same as non-preferred brand drugs	Same as non-preferred brand drugs	
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	No charge	20% <u>coinsurance</u>	<p>Prior authorization required to avoid penalty of lesser of \$500 or 20% of cost of services.</p>
	Physician/surgeon fees	No charge	20% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$35 <u>copay</u> /visit Pre-October 2, 2011 Retirees: no charge	\$35 <u>copay</u> /visit Pre-October 2, 2011 Retirees: no charge	<u>Copay</u> waived if admitted.
	<u>Emergency medical transportation</u>	No charge	No charge	None.
	<u>Urgent care</u>	\$15 <u>copay</u> /visit Pre-1999 Retiree: \$5 <u>copay</u> /visit	20% <u>coinsurance</u>	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% <u>coinsurance</u>	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 <u>medically necessary</u> .
	Physician/surgeon fees	No charge	20% <u>coinsurance</u>	Prior authorization required to avoid penalty of lesser of \$500 or 20% of cost of services.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 <u>copay</u> /visit Pre-1999 Retirees: \$5 <u>copay</u> /visit	20% <u>coinsurance</u>	None.
	Inpatient services	No charge	20% <u>coinsurance</u>	Prior authorization required to avoid penalty of lesser of \$500 or 20% of cost of services.
If you are pregnant	Office visits	\$15 <u>copay</u> /first visit only Pre-1999 Retiree: \$5 <u>copay</u> /initial visit only	20% <u>coinsurance</u>	Cost sharing does not apply for <u>preventive care services</u> . Depending on the type of services, a <u>copay</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described within another section (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	20% <u>coinsurance</u>	Prior authorization required to avoid penalty of lesser of \$500 or 20% of cost of services.
	Childbirth/delivery facility services	No charge	20% <u>coinsurance</u>	
If you need help	<u>Home health care</u>	No charge	20% <u>coinsurance</u>	Limit: 200 visits/calendar year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
recovering or have other special health needs	<u>Rehabilitation services</u>	No charge	20% <u>coinsurance</u>	Out-of-network physical, occupational, chiropractic, speech and autism therapy limit: 30 visits/calendar year. Prior authorization required (except for pre-1999 retirees) to avoid penalty of lesser of \$500 or 20% of cost of services. Speech therapy covered only for treatment resulting from autism, stroke, tumor removal, injury or congenital anomalies of the oropharynx.
	<u>Habilitation services</u>	Not covered	Not covered	You must pay 100% of this service, even in-network.
	<u>Skilled nursing care</u>	No charge	20% <u>coinsurance</u>	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.
	<u>Durable medical equipment</u>	No charge	20% <u>coinsurance</u>	Prior authorization required to avoid penalty of lesser of \$500 or 20% of cost of services.
	<u>Hospice services</u>	No charge	20% <u>coinsurance</u>	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 <u>copay</u> /visit	50% <u>coinsurance</u>	Limit: 1 visit/calendar year. <u>Copay</u> 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 dental check-up
- Children's glasses
- Cosmetic surgery
- Dental care (adult)
- Habilitation services
- 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 (Oxford limit: 20 visits/year; Anthem: 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 24 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](http://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 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

UnitedHealthcare/Oxford  
P.O. Box 30432  
Salt Lake City, UT 84130-0432  
Member Service Associates: 800-385-9055

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**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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 (Anthem) / 800-385-9055 (Oxford).

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-922-2232 (Anthem) / 800-385-9055 (Oxford).

如果需要中文的帮助， ☎☎打☎个号☎ 800-922-2232 (Anthem) / 800-385-9055 (Oxford).

Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 800-922-2232 (Anthem) / 800-385-9055 (Oxford).

-----*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 <u>plan's</u> overall <u>deductible</u>	\$350
■ <u>Specialist copayment</u>	\$5
■ 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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
---------------------------	-----------------

In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$350
<u>Copays</u>	\$20
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$430</b>

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

■ The <u>plan's</u> overall <u>deductible</u>	\$350
■ <u>Specialist copayment</u>	\$5
■ 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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
---------------------------	----------------

In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$350
<u>Copays</u>	\$560
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$970</b>

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

■ The <u>plan's</u> overall <u>deductible</u>	\$350
■ <u>Specialist copayment</u>	\$5
■ 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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
---------------------------	----------------

In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$350
<u>Copays</u>	\$100
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$450</b>

**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.