



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, copayment, 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:
<b>What is the overall <u>deductible</u>?</b>	In-network: <b>\$350</b> /Individual; <b>\$1,400</b> /Family <b>Waived for HEP Members and pre-October 2, 2011, Retirees.</b>	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.
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. Primary care and <u>specialist</u> office visits, <u>preventive care</u> , <u>prescription drugs</u> , <u>emergency room care</u> , urgent care, mental health and substance abuse outpatient services, and eye exams 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>copayment</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>
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	Medical: In-network: <b>\$2,000</b> /individual; <b>\$4,000</b> /family Prescription drugs: <b>\$4,600</b> /individual; <b>\$9,200</b> /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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<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> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.anthem.com/statect">www.anthem.com/statect</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 full cost if you use an <u>out-of-network provider</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.

Important Questions	Answers	Why This Matters:
Do you need a <b>referral</b> to see a <b>specialist</b> ?	No.	You can see the <b>specialist</b> you choose without a <b>referral</b> .

 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 <u>In-Network Provider</u> (You will pay the least)	<u>Non-Preferred In-Network Provider</u>	<u>Out-of-Network Provider</u> (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. <u>Deductible</u> does not apply.	\$15 <u>copay</u> /visit. Retired before 1999: \$5 <u>copay</u> /visit <u>Deductible</u> does not apply.	Not Covered	None.
	<u>Specialist</u> visit	No charge. <u>Deductible</u> does not apply.	\$15 <u>copay</u> /visit. Retired before 1999: \$5 <u>copay</u> /visit <u>Deductible</u> does not apply.	Not covered	None.
	<u>Preventive care/screening/immunization</u>	No charge. <u>Deductible</u> does not apply.	No charge. <u>Deductible</u> does not apply.	Not covered	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> .	Not covered	None.
	Imaging (CT/PET scans, MRIs)	No charge.	20% <u>coinsurance</u> .	Not covered	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 <u>In-Network Provider</u> (You will pay the least)	<u>Non-Preferred In-Network Provider</u>	<u>Out-of-Network Provider</u> (You will pay the most)	
<p><b>If you need drugs to treat your illness or condition</b> More information about <b><u>prescription drug coverage</u></b> 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	<p>Preferred generic: Non-Maintenance: \$5 <u>copay</u>/retail; Maintenance: \$5 <u>copay</u>/mail order/maintenance drug pharmacy. Non-preferred generic: Non-Maintenance: \$10 <u>copay</u>/retail; Maintenance: \$10 <u>copay</u>/mail order/maintenance drug pharmacy.</p> <p>Retired July 2, 2009 – October 1, 2011: Non-Maintenance: \$5 <u>copay</u>/retail; Maintenance: \$0 <u>copay</u>/initial fill/mail order/maintenance drug pharmacy.</p> <p>Pre-July 1, 2009 retirees: Non-Maintenance: \$3 <u>copay</u>/retail; Maintenance: \$0 <u>copay</u>/initial fill/mail order/maintenance drug pharmacy</p>			<p><u>Deductible</u> does not apply to <u>prescription drugs</u>. See details of your coverage for slightly adjusted <u>copays</u> for persons retired between July 1, 2009 and October 1, 2011, and after October 1, 2011. Check 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 after first retail fill. Penalty may apply if brand name drug is requested when a generic is available. Some drugs may require prior authorization. No charge for FDA-approved generic contraceptives (or brand name contraceptives if generic is medically inappropriate). <u>Prescription drugs</u> purchased at retail pharmacy limited to a maximum 30-day supply; <u>prescription drugs</u> purchased through mail order pharmacy limited to a maximum 90-day supply. <u>Prescription drug coverage</u> is separately administered.</p>
	Preferred brand drugs	<p>Maintenance: \$25 <u>copay</u>/retail; Maintenance: \$25<u>copay</u>/initial fill//mail order/Maintenance drug pharmacy. Retired July 2, 2009 – October 1, 2011: Non-Maintenance: \$10 <u>copay</u>/retail; Maintenance: \$10 <u>copay</u>/initial fill; \$0 <u>copay</u>/mail order/Maintenance drug pharmacy.</p> <p>Retired before July 1, 2009: Non-Maintenance: \$6 <u>copay</u>/retail; Maintenance: \$0 <u>copay</u>/initial fill/mail order/maintenance drug pharmacy.</p>		20% <u>coinsurance</u> for acute medication refills at non-participating network pharmacy	
	Non-preferred brand drugs	<p>Non-Maintenance: \$40 <u>copay</u>/retail; Maintenance: \$40 <u>copay</u>/initial fill//mail order/Maintenance drug pharmacy. Retired July 2, 2009 – October 1, 2011: \$25 <u>copay</u>/retail; maintenance: \$0 <u>copay</u>/initial fill/mail order/maintenance drug pharmacy Retired before July 1, 2009: Non-Maintenance: \$6 <u>copay</u>/retail; maintenance: \$0 <u>copay</u>/initial fill/mail order/ Maintenance drug pharmacy.</p>			
	<u>Specialty drugs</u>	Same as non-preferred brand drugs		Same as non-preferred brand drugs	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred <u>In-Network Provider</u> (You will pay the least)	<u>Non-Preferred In-Network Provider</u>	<u>Out-of-Network Provider</u> (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge		Not covered	Prior authorization required to avoid penalty of lesser of \$500 or 20% of cost of services.
	Physician/surgeon fees	No charge		Not covered	
If you need immediate medical attention	<u>Emergency room care</u>	\$250 <u>copay</u> /visit. Retired October 2, 2011 – October 1, 2017: \$35 <u>copay</u> /visit. Retired before October 2, 2011: No charge. <u>Deductible</u> does not apply.		\$250 <u>copay</u> /visit. Retired October 2, 2011 – October 1, 2017: \$35 <u>copay</u> /visit. Retired before October 2, 2011: No charge	\$250 <u>copayment</u> waived if admitted or is actual emergency.
	<u>Emergency medical transportation</u>	No charge		No charge	None.
	<u>Urgent care</u>	\$15 <u>copay</u> /visit. Retired before 1999: \$5 <u>copay</u> /visit <u>Deductible</u> does not apply.		Not covered	Out-of-network services not covered except <u>urgent care</u> services outside the United States
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge		Not covered	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		Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred <u>In-Network Provider</u> (You will pay the least)	<u>Non-Preferred In-Network Provider</u>	<u>Out-of-Network Provider</u> (You will pay the most)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$15 <u>copay</u> /visit. Retired before 1999: \$5 <u>copay</u> /visit. <u>Deductible</u> does not apply.		Not covered	None.
	Inpatient services	No charge		Not covered	Prior authorization required to avoid penalty of lesser of \$500 or 20% of cost of services.
<b>If you are pregnant</b>	Office visits	\$15 <u>copay</u> /visit. Retired before 1999: \$5 <u>copay</u> /visit. <u>Deductible</u> does not apply.		Not covered	Cost sharing does not apply for <u>preventive services</u> . Depending on the type of service, a <u>copay</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests & services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge		Not covered	Prior authorization required to avoid penalty of lesser of \$500 or 20% of cost of services.
	Childbirth/delivery facility services	No charge		Not covered	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	No charge		Not covered	Limit: 200 visits/calendar year.
	<u>Rehabilitation services</u>	No charge		Not covered	Prior authorization required (except pre-1999 retirees) to avoid penalty of lesser of \$500 or 20% of cost of services. 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.
	<u>Habilitation services</u>	No charge		Not covered	None.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred <u>In-Network Provider</u> (You will pay the least)	<u>Non-Preferred In-Network Provider</u>	<u>Out-of-Network Provider</u> (You will pay the most)	
	<u>Skilled nursing care</u>	No charge		Not covered	Prior authorization required to avoid penalty of lesser of \$500 or 20% of cost of services.
	<u>Durable medical equipment</u>	No charge		Not covered	Prior authorization required for items over \$500 to avoid penalty of lesser of \$500 or 20% of cost of services.
	<u>Hospice services</u>	No charge		Not covered	Prior authorization required to avoid penalty of lesser of \$500 or 20% of cost of services.
<b>If your child needs dental or eye care</b>	Children's eye exam	\$15 <u>copay</u> /visit <u>Deductible</u> does not apply.		Not covered	Limit: 1 exam visit/calendar year. <u>Copay</u> waived for HEP members 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)
- Non-emergency care when traveling outside the United States (urgent care covered)
- Long-term care
- Routine foot care
- Weight loss programs (except as required by the health reform law)

#### **Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Acupuncture (limit: 20 visits/year by Oxford; covered by Anthem only if medically necessary for osteoarthritis or nausea and vomiting associated with surgery, chemotherapy or pregnancy).
- Bariatric surgery (prior authorization required)
- Chiropractic care
- Hearing aid (limit: 1 set/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 1-877-267-2323 x61565 or [www.cciio.cms.gov](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 1-800-318-2596.

**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  
1-860-297-3910

United Healthcare/Oxford  
P.O. Box 30432  
Salt Lake City, UT 84130-0432  
Member Services Associates: 1-800-385-9055

CVS/Caremark  
Prescription Claim Appeals MC109  
P.O. Box 52084  
Phoenix, AZ 85072-2084  
Fax: 1-866-443-1172

Additionally, a consumer assistance program can help you file your appeal. Contact the Connecticut Office of the Healthcare Advocate at 833-466-4446.

**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 1-800-385-9055.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-385-9055.

如果需要中文的帮助, 请拨打这个号码 1-800-385-9055.

Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-385-9055.

————— *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, copayments 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)

■ <b>The plan's overall deductible</b>	<b>\$350</b>
■ <b>Specialist copayment</b>	<b>\$15</b>
■ <b>Hospital (facility)</b>	<b>\$0</b>
■ <b>Other</b>	<b>\$0</b>

**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)

■ <b>The plan's overall deductible</b>	<b>\$350</b>
■ <b>Specialist copayment</b>	<b>\$15</b>
■ <b>Hospital (facility)</b>	<b>\$0</b>
■ <b>Other</b>	<b>\$0</b>

**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>	\$70
<u>Copays</u>	\$235
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$365</b>

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

■ <b>The plan's overall deductible</b>	<b>\$350</b>
■ <b>Specialist copayment</b>	<b>\$15</b>
■ <b>Hospital (facility)</b>	<b>\$0</b>
■ <b>Other cost sharing</b>	<b>\$0</b>

**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>	\$310
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$660</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://osc.ct.gov/benefits.htm>.

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