




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, <https://eoc.anthem.com/eocdps/fi>. 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 [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call (888) 224-4896 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$2,750/person or \$5,500/family for Value Tier 1 In- <a href="#">Network</a> (INET) <a href="#">Providers</a> and Participating Tier 2 In- <a href="#">Network</a> (INET) <a href="#">Providers</a> combined. \$10,000/person or \$20,000/family for Out-of- <a href="#">Network</a> (OON) <a href="#">Providers</a> .	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive Care</a> for Value Tier 1 In- <a href="#">Network</a> (INET) and Participating Tier 2 In- <a href="#">Network</a> (INET) <a href="#">Providers</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$5,500/person or \$11,000/family for Value Tier 1 In- <a href="#">Network</a> (INET) <a href="#">Providers</a> and Participating Tier 2 In- <a href="#">Network</a> (INET) <a href="#">Providers</a> combined. \$20,000/person or \$40,000/family for Out-of- <a href="#">Network</a> (OON) <a href="#">Providers</a> .	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if	Yes, Century Preferred Tiered.	You pay the least if you use a <a href="#">provider</a> in Value Tier 1 In- <a href="#">Network</a> (INET). You pay more if

you use a <a href="#">network provider</a> ?	See <a href="http://www.anthem.com">www.anthem.com</a> or call (888) 224-4896 for a list of <a href="#">network providers</a> .	you use a <a href="#">provider</a> in Participating Tier 2 In- <a href="#">Network</a> (INET). You will pay the most if you use an <a href="#">Out-of-Network (OON) Provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">Out-of-Network (OON) Provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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
		Value Tier 1 In-Network (INET) Provider (You will pay the least)	Participating Tier 2 In-Network (INET) Provider (You will pay more)	Out-of-Network (OON) Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	0% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Specialist</a> visit	0% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Preventive care</a> / <a href="#">screening</a> / immunization	No charge	No charge	50% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	0% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Costs may vary by site of service. Includes coverage for Breast Tomosynthesis.
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Costs may vary by site of service.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a>	Tier 1 - Typically Generic	Not Applicable	\$5/prescription (retail) and \$10/prescription (home delivery)	50% <a href="#">coinsurance</a> (retail) and Not covered (home delivery)	Essential Drug List
	Tier 2 - Typically <a href="#">Preferred</a> Brand	Not Applicable	\$25/prescription (retail) and \$50/prescription (home delivery)	50% <a href="#">coinsurance</a> (retail) and Not covered (home delivery)	*See Prescription Drug section
	Tier 3 - Typically Non- <a href="#">Preferred</a> Brand and Generic drugs	Not Applicable	\$40/prescription (retail) and \$80/prescription (home delivery)	50% <a href="#">coinsurance</a> (retail) and Not covered (home delivery)	

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/fi>.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Value Tier 1 In-Network (INET) Provider (You will pay the least)	Participating Tier 2 In-Network (INET) Provider (You will pay more)	Out-of-Network (OON) Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Costs may vary by site of service
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$150 <a href="#">copayment</a> after deductible	\$150 <a href="#">copayment</a> after deductible	Covered as In- <a href="#">Network</a>	-----none-----
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	Covered as In- <a href="#">Network</a>	-----none-----
	<a href="#">Urgent care</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	0% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	150 days/benefit period for Inpatient rehabilitation and skilled nursing services combined.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit	Office Visit	Office Visit	Office Visit
		0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
	Inpatient services	Other Outpatient	Other Outpatient	Other Outpatient	Other Outpatient
		0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
If you are pregnant	Office visits	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	0% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	0% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	100 visits/benefit period for Home Health and Private Duty Nursing combined.
	<a href="#">Rehabilitation services</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	*See Therapy Services section.
	<a href="#">Habilitation services</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/fi>.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Value Tier 1 In-Network (INET) Provider (You will pay the least)	Participating Tier 2 In-Network (INET) Provider (You will pay more)	Out-of-Network (OON) Provider (You will pay the most)	
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	150 days/benefit period for Inpatient rehabilitation and skilled nursing services combined.
	<a href="#">Durable medical equipment</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	*See <a href="#">Durable Medical Equipment</a> Section
	<a href="#">Hospice services</a>	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	Not covered	-----none-----
	Children's glasses	Not covered	Not covered	Not covered	-----none-----
	Children's dental check-up	Not covered	Not covered	Not covered	-----none-----

#### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Bariatric Surgery</li> <li>• Dental care (Pediatric)</li> <li>• Glasses for a child</li> <li>• Routine eye care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental Check-up</li> <li>• Long-term care</li> <li>• Routine foot care unless you have been diagnosed with diabetes</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care (Adult)</li> <li>• Eye exams for a child</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Weight loss programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Acupuncture Coverage is limited to Pain Management</li> <li>• Infertility treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care 20 visits/benefit period</li> <li>• Private-duty nursing 100 visits/benefit period combined with Home Health</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing Aids 1 Item(s) every 2 benefit periods</li> </ul>

**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: Connecticut Department of Insurance, 153 Market Street, 7th Floor, Hartford, CT 06103, (860) 297-3000, (800) 203-3447, Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or contact Anthem at the number on the back of your ID card. 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](#)

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/fi>.

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:

ATTN: Grievances and Appeals, P.O. Box 1038, North Haven, CT 06473-4201

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

Connecticut Department of Insurance, 153 Market Street, 7th Floor, Hartford, CT 06103, (860) 297-3000, (800) 203-3447

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

**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](#).

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

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/fi>.

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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000
■ <a href="#">Specialist coinsurance</a>	10%	■ <a href="#">Specialist coinsurance</a>	10%	■ <a href="#">Specialist coinsurance</a>	10%
■ Hospital (facility) <a href="#">coinsurance</a>	10%	■ Hospital (facility) <a href="#">coinsurance</a>	10%	■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%	■ Other <a href="#">coinsurance</a>	10%	■ Other <a href="#">coinsurance</a>	10%
<p>This EXAMPLE event includes services like:</p> <p><a href="#">Specialist</a> office visits (<i>prenatal care</i>)                      Childbirth/Delivery Professional Services                      Childbirth/Delivery Facility Services  <a href="#">Diagnostic tests</a> (<i>ultrasounds and blood work</i>)  <a href="#">Specialist</a> visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like:</p> <p><a href="#">Primary care physician</a> office visits (<i>including disease education</i>)  <a href="#">Diagnostic tests</a> (<i>blood work</i>)  <a href="#">Prescription drugs</a>  <a href="#">Durable medical equipment</a> (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like:</p> <p><a href="#">Emergency room care</a> (<i>including medical supplies</i>)  <a href="#">Diagnostic test</a> (<i>x-ray</i>)  <a href="#">Durable medical equipment</a> (<i>crutches</i>)  <a href="#">Rehabilitation services</a> (<i>physical therapy</i>)</p>	
<b>Total Example Cost</b>	<b>\$12,800</b>	<b>Total Example Cost</b>	<b>\$7,400</b>	<b>Total Example Cost</b>	<b>\$1,900</b>
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<a href="#">Cost Sharing</a>		<a href="#">Cost Sharing</a>		<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$3,000	<a href="#">Deductibles</a>	\$3,000	<a href="#">Deductibles</a>	\$1,400
<a href="#">Copayments</a>	\$20	<a href="#">Copayments</a>	\$1,600	<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,000	<a href="#">Coinsurance</a>	\$100	<a href="#">Coinsurance</a>	\$500
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$60	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$4,080</b>	<b>The total Joe would pay is</b>	<b>\$4,760</b>	<b>The total Mia would pay is</b>	<b>\$1,900</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

## Language Access Services:

(TTY/TDD: 711)

**Albanian (Shqip):** Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (888) 224-4896

**Amharic (አማርኛ):** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (888) 224-4896 ይደውሉ።

**Arabic (العربية):** إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (888) 224-4896.

**Armenian (հայերեն):** Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (888) 224-4896:

**Bassa (Bàsɔ̀ Wùdù):** M̄ dyi dyi-diè-djè b̄é b̄édjé b̄á céè-djè n̄ià k̄e dyí ní, ɔ̀ m̄ò n̄i dyí-b̄èdjèin-djè b̄é m̄ k̄é gbo-kpá-kpá k̄è b̄ĩ kp̄ō djé m̄ b̄ídjí-wùdùùn b̄ó pídyi. B̄é m̄ k̄é wuɖu-zìin-nyò djò gbo wùdù k̄e, djá (888) 224-4896.

**Bengali (বাংলা):** যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (888) 224-4896 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (888) 224-4896 သို့ ခေါ်ဆိုပါ။

**Chinese (中文):** 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(888) 224-4896。

**Dinka (Dinka):** Na nɔŋ thiëc në ke de yā thorë, ke yin nɔŋ loŋ bē yi kuony ku wër alëu bē gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kør yin ba jam wënë ran ye thok geryic, ke yin col (888) 224-4896.

**Dutch (Nederlands):** Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (888) 224-4896.

**Farsi (فارسی):** در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (888) 224-4896 تماس بگیرید.

## Language Access Services:

**French (Français) :** Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (888) 224-4896.

**German (Deutsch):** Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (888) 224-4896.

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