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 http://www.osc.ct.gov/ctpartner/docs/PartMedIPlanDoceff01012016updt9192016.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 deductible?	In-Network: $350/individual; $1,400/family- waived for HEP members Out-of-Network: $300/Individual; $900/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care and prescription drugs are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copay or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical: $2,000/individual; $4,000/family Prescription drugs: $4,600/individual; $9,200/family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Out-of- network deductible and cost sharing, premiums, balance-billing charges, penalties for failure to obtain prior authorization for services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See http://partnershipstateofct.welcometouhc.com/home or call 800-385-9055 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
		Preferred In-Network Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (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	$15 copay/visit. Waived if no in-state preferred provider	20% coinsurance	None.
	Specialist visit	No charge			
	Preventive care/screening/ immunization	No charge	No charge. Deductible does not apply.		You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	40% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	40% coinsurance	Prior authorization required to avoid penalty: lesser of $500/20% of cost.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.osc.ct.gov/benefits/pharmacy.htm	Generic drugs	Preferred generic: Retail: $5 copay; Mail order & maintenance drugs: $5 copay. Non-preferred generic: Retail: $10 copay; Mail order & maintenance drugs: $10 copay		20% coinsurance for non-participating pharmacy	Retail: 30-day supply; Mail order: 90-day supply. Deductible does not apply to prescription drugs. Check details of your Rx coverage at: www.osc.ct.gov/benefits/pharmacy.htm. Maintenance drugs must be filled by mail order or by Maintenance Network pharmacy after first retail fill. Penalty may apply if brand name drug is requested when a generic is available. Some drugs require prior authorization. No charge for FDA-approved generic contraceptives (or brand name contraceptives if generic is medically inappropriate).
	Preferred brand drugs	Retail: $25 copay; Mail order & maintenance drugs: $25 copay.		20% coinsurance for non-participating pharmacy	
	Non-preferred brand drugs	Retail: $40 copay; Mail order & maintenance drugs: $40 copay.		20% coinsurance for non-participating pharmacy	
	Specialty drugs	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 In-Network Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge		20% coinsurance	Prior authorization required to avoid penalty of lesser of $500 or 20% of covered services.
	Physician/surgeon fees	No charge			
If you need immediate medical attention	Emergency room care	$250 copay/visit		Same as in-network plus excess over allowed amount.	Copay waived if admitted.
	Emergency medical transportation	No charge		No charge	None.
	Urgent care	$15 copay/visit		20% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge		20% coinsurance	Prior authorization required to avoid penalty of lesser of $500 or 20% of covered services. No coverage in excess of cost of a semi-private room unless medically necessary.
	Physician/surgeon fees	No charge		20% coinsurance	Prior authorization required to avoid penalty of lesser of $500 or 20% of covered services.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/visit		20% coinsurance	None.
	Inpatient services	No charge		20% coinsurance	Prior authorization required to avoid penalty of lesser of $500 or 20% of covered services.
If you are pregnant	Office visits	$15 copay/first visit only		20% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of service, a copay, coinsurance, or deductible may apply. Maternity care may include tests & services described somewhere else in the SBC (i.e., ultrasound).

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred In-Network Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	No charge		20% coinsurance	Prior authorization required for stay in excess of 48 hours (96 hours for cesarean delivery) to avoid penalty of lesser of $500 or 20% of covered services.
	Childbirth/delivery facility services				
If you need help recovering or have other special health needs	Home health care	No charge		20% coinsurance	Limit: 200 visits/calendar year.
	Rehabilitation services	No charge		20% coinsurance	Prior authorization required to avoid penalty of lesser of $500 or 20% of covered services. Out-of-network physical, occupational, chiropractic, speech & autism therapy limit: 30 visits/condition/calendar year. Speech therapy covered only for treatment resulting from autism, stroke, tumor removal, injury or congenital anomalies of oropharynx.
	Habilitation services	Not covered.		Not covered.	You must pay 100% of this service, even in-network.
	Skilled nursing care	No charge		20% coinsurance	Out-of-network limit: 60 visits/ year/ person Prior authorization required to avoid penalty of lesser of $500 or 20% of covered services.
	Durable medical equipment	No charge		20% coinsurance	Prior authorization required for items over $500 to avoid penalty of lesser of $500 or 20% of covered services.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred In-Network Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
	Hospice services	No charge		20% coinsurance	Inpatient services: prior authorization required to avoid penalty of lesser of $500 or 20% of covered services. Out-of-network inpatient services limit: 60 days/person/calendar year. Out-of-network in-home services limit: 200 visits/calendar year
If your child needs dental or eye care	Children's eye exam	$15 copay/visit		50% coinsurance	Limit: 1 visit/calendar year performed as part of an exam.
	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
- Non-emergency care when traveling outside the United States (urgent care covered)
- Long-term care
- Routine foot care (except when medically necessary for treatment of diabetes)
- 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 (limit: 20 visits per calendar year)
- Bariatric surgery (prior authorization required)
- Chiropractic care (limit: 30 visits per calendar year for out-of-network services)
- Hearing aids (limit: 1 set per 24 month period; prior authorization required)
- Infertility treatment (prior authorization required)
- Non-emergency care when traveling outside the United States (urgent care only)
- Private-duty nursing (prior authorization required)
- Routine eye care (adult, limit: 1 exam per calendar 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. 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 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 Health Care Advocate at 1-866-466-4446

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 1-800-385-9055.
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-385-9055 (UnitedHealthcare/Oxford).
如果需要中文的帮助，请拨打这个号码 1-800-385-9055 (UnitedHealthcare/Oxford).
Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-385-9055 (UnitedHealthcare/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 plan's overall deductible	$350
Specialist copayment	$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)*

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$350
Copays	$20
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$430

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

The plan's overall deductible	$350
Specialist copayment	$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)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$350
Copays	$560
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$970

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

The plan's overall deductible	$350
Specialist copayment	$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)*

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$350
Copays	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$450

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.