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://www.anthem.com/cuhealthplan. 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/ or call (800) 735-6072 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,650**/single or **$3,300**/family for In-Network Providers. **$3,300**/single or **$6,600**/family for Out-of-Network	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 for In-Network Providers.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment 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?	**$3,300**/single or **$6,600**/family for In-Network Providers. **$6,600**/single or **$13,200**/family for Out-of-Network Providers.	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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Pre-Authorization Penalties, Premiums, Balance-Billing 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.
Will you pay less if you use a network provider?	Yes, PPO. See www.anthem.com/cuhealthplan or call (800) 735-6072 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 **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
		In-Network Provider (You will pay the least)	Non-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	15% coinsurance after deductible	35% coinsurance after deductible	--------none--------
	Specialist visit	15% coinsurance after deductible	35% coinsurance after deductible	--------none--------
	Preventive care/screening/ immunization	$0 /visit	35% coinsurance after deductible	There may be other levels of cost share that are contingent on how services are provided. 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)	15% coinsurance after deductible	35% coinsurance after deductible	-------none--------
	Imaging (CT/PET scans, MRIs)	15% coinsurance after deductible	35% coinsurance after deductible	Failure to obtain pre-authorization may result in reduced or no coverage.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** under CVS's Standard Control Formulary with Advanced Control Specialty Formulary is available at https://info.caremark.com/acsdruglist	Tier 1 - Typically Generic	After deductible: 10% coinsurance for up to a 30- day supply at Caremark Retail Network Pharmacies and 5% coinsurance for a 31 to 90-day supply at CVS Retail, Costco, Kroger or CVS mail order	20% coinsurance after deductible for up to a 30-day supply	**Specialty RX:** Per fill, a maximum of up to 30 days of Specialty medication may be purchased at a retail pharmacy. After 3 fills, CVS Specialty Pharmacy must be used for Specialty medication to be covered. **Maintenance medication:** Per fill, a maximum of up to 30 days of maintenance medication may be purchased at a retail pharmacy. After 3 fills, CVS Retail Pharmacies, Costco, Kroger, or CVS Mail Order Pharmacy must be used for maintenance medications, for up toa 90-day supply to be covered.
	Tier 2 - Typically Preferred Brand	After deductible: 20% coinsurance for up to a 30 day supply at Caremark Retail Network Pharmacies and 15% coinsurance for a 31 to 90-day supply at CVS Retail, Costco, Kroger or CVS mail order	20% coinsurance after deductible for up to a 30-day supply	

				Generic Preventive Therapy Drugs: Certain medications and supplies may be obtained at in network pharmacies with no applicable copayment (100% covered). Please contact CVS member services for additional information CVS Caremark Customer Care: 1-888-964-0121

* For more information about limitations and exceptions, see **plan** or policy document at https://www.anthem.com/cuhealthplan.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Tier 3 - Typically Non-Preferred Brand	After deductible: 20% coinsurance for up to a 30- day supply at Caremark Retail Network Pharmacies and 15% coinsurance for a 31 to 90-day supply at CVS Retail, Costco, Kroger or CVS mail order	20% coinsurance after deductible for up to a 30-day supply	**Diabetic Medication & Supplies:** Members diagnosed with diabetes may be eligible to have insulin, **generic** diabetic medication, pumps & supplies (needles, syringes, lancets, test strips) obtained at in network pharmacies with no applicable copayment (100% covered). Please contact member services for additional information. CVS Caremark Customer Care: 1-888-964-0121 Prescription Drugs will always be dispensed as ordered by your Provider and by applicable State Pharmacy Regulations, however you may have higher out-of-pocket costs. You may request, or your Provider may order, the Brand Name Drug. However, if a Generic Drug is available, you will need to pay the cost difference between the Generic and Brand Name Drug, in addition to your tier Copayment. The cost difference between the Generic and Brand Name Drug does not contribute to the Out-of-Pocket Annual Maximum. By law, Generic and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. The Plan reserves the right, at its discretion, to remove certain higher cost Generic Drugs from this coverage.
	Tier 4 - Typically Specialty Drugs	After deductible: 20% coinsurance for up to a 30 day supply at Caremark Retail Network Pharmacies and 15% coinsurance at CVS Retail, Costco, Kroger or CVS mail order for up to a 30-day supply	20% coinsurance after deductible for up to a 30-day supply	

* For more information about limitations and exceptions, see **plan** or policy document at https://www.anthem.com/cuhealthplan.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance after deductible	35% coinsurance after deductible	Failure to obtain pre-authorization may result in reduced or no coverage.
	Physician/surgeon fees	15% coinsurance after deductible	35% coinsurance after deductible	--------none--------
If you need immediate medical attention	Emergency room care	15% coinsurance after deductible	Covered as In-Network	There may be other levels of cost share that are contingent on how services are provided.
	Emergency medical transportation	15% coinsurance after deductible	Covered as In-Network	--------none--------
	Urgent care	15% coinsurance after deductible	35% coinsurance after deductible	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance after deductible	35% coinsurance after deductible	Failure to obtain pre-authorization may result in reduced or no coverage.
	Physician/surgeon fees	15% coinsurance after deductible	35% coinsurance after deductible	--------none--------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit 15% coinsurance after deductible; Other Outpatient 15% coinsurance after deductible	Office Visit 35% coinsurance after deductible; Other Outpatient 35% coinsurance after deductible	Failure to obtain pre-authorization may result in reduced or no coverage.
	Inpatient services	15% coinsurance after deductible	35% coinsurance after deductible	Failure to obtain pre-authorization may result in reduced or no coverage.
If you are pregnant	Office visits	15% coinsurance after deductible	35% coinsurance after deductible	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) For inpatient admission, failure to obtain pre-authorization may result in reduced or no coverage.
	Childbirth/delivery professional services	15% coinsurance after deductible	35% coinsurance after deductible	
	Childbirth/delivery facility services	15% coinsurance after deductible	35% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	15% coinsurance after deductible	35% coinsurance after deductible	100 visits/calendar year combined for In-Network and Out-of-Network. Failure to obtain pre-authorization may result in reduced or no coverage.
	Rehabilitation services	15% coinsurance after deductible	35% coinsurance after deductible	Outpatient coverage of physical, occupational and speech therapies is

* For more information about limitations and exceptions, see **plan** or policy document at https://www.anthem.com/cuhealthplan.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Habilitation services	15% coinsurance after deductible	35% coinsurance after deductible	limited to 40 visits each per plan year combined In-Network and Out-of-Network. All rehabilitation and habilitation visits count toward your rehabilitation visit limit.
	Skilled nursing care	15% coinsurance after deductible	35% coinsurance after deductible	Failure to obtain pre-authorization may result in reduced or no coverage. Covers up to 100 days per plan year combined In-Network and Out-of-Network.
	Durable medical equipment	15% coinsurance after deductible	Not covered	Failure to obtain pre-authorization may result in reduced or no coverage. Includes 1 wig following cancer treatment.
	Hospice services	15% coinsurance after deductible	35% coinsurance after deductible	Failure to obtain pre-authorization may result in reduced or no coverage.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	--------none--------
	Glasses	Not covered	Not covered	
	Dental check-up	Not covered	Not covered	--------none--------

* For more information about limitations and exceptions, see **plan** or policy document at https://www.anthem.com/cuhealthplan.

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.)

- Private-duty nursing
- Weight loss programs
- Cosmetic surgery
- Long-term care
- Routine foot care unless you have been diagnosed with diabetes
- Routine vision exam
- Dental care (adult)
- Preauthorization - You may have to pay for all or a portion of any test, equipment, service or procedure that is not preauthorized. To find out which services require Preauthorization and to be sure that Preauthorization has been given, you may contact us.

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

- Acupuncture (20 visit maximum)
- Most coverage provided outside the United States www.bcbsglobalcore.com
- Bariatric surgery
- Hearing Aids (1 pair/5 years)
- Chiropractic care (20 visit maximum)
- Infertility treatment

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: Department of Labor's Employee Benefits Security Administration at (866) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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:

ATTN: Grievances and Appeals, 700 Broadway, Mail Stop CO0104-0430, Denver, CO 80273

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

Division of Insurance, ICARE Section, 1560 Broadway, Suite 850, Denver, Colorado 80202, (303) 894-7490

* For more information about limitations and exceptions, see **plan** or policy document at https://www.anthem.com/cuhealthplan.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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://www.anthem.com/cuhealthplan.

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)

The plan's overall deductible	$1,650
Specialist *coinsurance*	15%
Hospital (facility) *coinsurance*	15%
Other *coinsurance*	15%

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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,650
Copayments	$0
Coinsurance	$1,679
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,300**

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

The plan's overall deductible	$1,650
PCP *coinsurance*	15%
Hospital (facility) *coinsurance*	15%
Other *coinsurance*	15%

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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,650
Copayments	$0
Coinsurance	$872
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,522**

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

The plan's overall deductible	$1,650
Specialist *coinsurance*	15%
Hospital (facility) *coinsurance*	15%
Other *coinsurance*	15%

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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,650
Copayments	$0
Coinsurance	$54
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,704**

The plan would be responsible for the other costs of these EXAMPLE covered 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 (800) 735-6072

Amharic (አማርኛ)፦ ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (800) 735-6072 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 (800) 735-6072.

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՝ (800) 735-6072:

Bassa (Bǎsɔ̀ɔ̀ Wùdù): M̀ dyi dyi-diè-dɛ̀ bě bédé bá céè-dɛ̀ nìà kɛ dyí ní, ɔ mɔ̀ nì dyí-bèdɛ̀ìn-dɛ̀ bé m̀ ké gbo-kpá-kpá kè bɔ̃ kpɔ̃ dé m̀ bídí-wùdùǔn bó pídyi. Bé m̀ ké wudu-zììn-nyɔ̀ dò gbo wùdù kɛ, dá (800) 735-6072.

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 (800) 735-6072 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် (800) 735-6072 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 (800) 735-6072。

Dinka (Dinka): Na nɔŋ thiëëc në ke de yä thorë, ke yin nɔŋ loŋ bë yi kuony ku wɛr alëu bë gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kɔr yin ba jam wënë ran ye thok geryic, ke yin cɔl (800) 735-6072.

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 (800) 735-6072.

Farsi (فارسي) : در صورتي كه سؤالي پيرامون اين سند داريد، اين حق را داريد كه اطلاعات و كمک را بدون هيچ هزينه اى به زبان مادرىتان دريافت كنيد. براى گفتگو با يک مترجم شفاهى، با شماره (800) 735-6072 تماس بگيريد.

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 (800) 735-6072.

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 (800) 735-6072.

Greek (Ελληνικά) Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (800) 735-6072.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (800) 735-6072.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (800) 735-6072.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (800) 735-6072

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (800) 735-6072.

Igbo (Igbo): *Ọ* bụr *ụ* na *ị* nwere ajụjụ ọ bụla gbasara akwụkwọ a, *ị* nwere ikike *ị*nweta enyemaka na ozi n'asụsụ g*ị* na akwụgh*ị* ụgwọ ọ bụla. Ka g*ị* na ọkọwa okwu kwuo okwu, kp*ọọ* (800) 735-6072.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (800) 735-6072.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (800) 735-6072.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (800) 735-6072

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(800) 735-6072 にお電話ください。

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