This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com/cuhealthplan or by calling 1-800-735-6072.

The contents of this form are subject to the provisions of the benefit booklet, which contains all terms, covenants and conditions of coverage. Consult the actual benefit booklet to determine the exact terms and conditions of coverage. This is not a Medicare Supplement or MediGap plan. Medicare is the primary payer for this plan; any medical covered services payable under this plan will be reduced by the amounts payable for the same expenses under Medicare Parts A and B. Coverage under this plan will be the Medicare allowed amount for those services covered by Medicare up to the maximum benefit allowance of the plan. Most medical services or supplies not covered under Medicare are not a covered benefit under this plan. **You must be enrolled in Medicare A and B to be eligible for this plan**. If you are not enrolled in Medicare A and B, you must contact your employer for eligibility into other programs.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Plan Year Deductible (Medical Only): January 1st, 2025 – December 31st, 2025 For in-network: **$240** per individual or per individual within a family coverage, per Plan Year. Does not apply to preventive care, services subject to a copayment and Child Health Supervision Services.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered **medical** services you use. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For **in-network**: **Medical: $1,200** Single (per individual) up to **$3,600** Family **Pharmacy: $1,200** Single (per individual) up to **$3,600** Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed 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**.

Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)

Common Medical Event	Services You May Need	Your Cost	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness (Part B)	20% coinsurance after deductible	Coverage for Medicare-approved charges not reimbursed by Medicare.
	Specialist visit (Part B)	20% coinsurance after deductible	Coverage for Medicare-approved charges not reimbursed by Medicare.
	Other practitioner office visit (Part B)	20% coinsurance after deductible	Coverage for Medicare-approved charges not reimbursed by Medicare.
	Preventive care/screening/ immunization	No coinsurance; 100% covered	Preventive services are not subject to deductible.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	Coverage for Medicare-approved charges not reimbursed by Medicare.
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	Coverage for Medicare-approved charges not reimbursed by Medicare.

Common Medical Event	Services You May Need	Your Cost	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** contact SilverScript (CVS Caremark) customer care at 1-833-252-6640	Tier 1 Generic drugs	**CVS Retail or CVS mail order Pharmacy:** $10 / prescription for up to a 30-day supply $20 / prescription for a 31 to 90-day supply on maintenance choice medications **Caremark Retail Network Pharmacies:** $10 / prescription for up to a 30-day supply $30 / prescription for a 31 to 90-day supply	**Specialty RX:** Per fill, a maximum of up to 30 days of Specialty medication. **Generic Preventive Therapy Drugs:** Certain medications and supplies may be obtained at in-network pharmacies with no applicable copayment (100% covered). Please contact SilverScript (CVS) member services for additional information. SilverScript (CVS Caremark) Customer Care: 1-833-252-6640 **Diabetic Medication & Supplies:** Members diagnosed with diabetes may be eligible to have insulin, **generic** diabetic medications, pumps & supplies (needles, syringes, lancets, test strips) obtained at in network pharmacies with no applicable coinsurance (100% covered).
	Tier 2 Preferred brand drugs	**CVS Retail or CVS mail order Pharmacy:** $50 / prescription for up to a 30-day supply $100 / prescription for a 31 to 90-day supply on maintenance choice medications **Caremark Retail Network Pharmacies:** $50 / prescription for up to a 30-day supply $150 / prescription for a 31 to 90-day supply	

	Tier 3 Non-preferred brand drugs	**CVS Retail or CVS mail order Pharmacy:** $75 / prescription for up to a 30-day supply $150 / prescription for a 31 to 90-day supply on maintenance choice medications **Caremark Retail Network Pharmacies:** $75 / prescription for up to a 30-day supply $225 / prescription for a 31 to 90-day supply	Please contact customer service for additional information. SilverScript (CVS Caremark) Customer Care:1-833-252-6640

Common Medical Event	Services You May Need	Your Cost	Limitations & Exceptions
	Tier 4 Specialty Orals and Injectable drugs	**CVS Retail, CVS mail order, or Caremark Retail Network Pharmacies:** $100 / prescription for up to a 30-day supply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	Coverage for Medicare-approved charges not reimbursed by Medicare.
	Physician/surgeon fees	20% coinsurance after deductible	Coverage for Medicare-approved charges not reimbursed by Medicare.
	Emergency room services	20% coinsurance after deductible	Coverage for Medicare-approved charges not reimbursed by Medicare.

If you need immediate medical attention	Emergency medical transportation	20% coinsurance after deductible	Coverage for Medicare-approved charges not reimbursed by Medicare.
	Urgent care	20% coinsurance after deductible	Coverage for Medicare-approved charges not reimbursed by Medicare.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	Failure to obtain pre-authorization may result in reduced or no coverage. Coverage for Medicare-approved charges not reimbursed by Medicare.
If you have a hospital stay (cont.)	Physician/surgeon fee	20% coinsurance after deductible	Coverage for Medicare-approved charges not reimbursed by Medicare.

Common Medical Event	Services You May Need	Your Cost	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance after deductible	Coverage for Medicare-approved charges not reimbursed by Medicare.
	Mental/Behavioral health inpatient services	20% coinsurance after deductible	Coverage for Medicare-approved charges not reimbursed by Medicare.
	Substance use disorder outpatient services	20% coinsurance after deductible	Coverage for Medicare-approved charges not reimbursed by Medicare.
	Substance use disorder inpatient services	20% coinsurance after deductible	Failure to obtain pre-authorization may result in reduced or no coverage. Coverage for Medicare-approved charges not reimbursed by Medicare.
If you need help recovering or have other special health needs	Physical, Occupational & Speech Therapy	20% coinsurance after deductible	Coverage for Medicare-approved charges not reimbursed by Medicare. Up to 20 visits each for children ages 3 to 6.
	Skilled nursing care	1st – 20th day – No charge, Medicare pays 100%. 21st – 100th day – 20% coinsurance after deductible	Coverage for Medicare-approved charges not reimbursed by Medicare.
	Durable medical equipment	20% coinsurance after deductible	Coverage for Medicare-approved charges not reimbursed by Medicare.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (limits apply)
- Chiropractic care
- Infertility treatment

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

Appeals:

Anthem Blue Cross and Blue Shield
Appeals Department
700 Broadway, CAT CO0104-0430
Denver, CO 80273

Grievances:

Anthem Blue Cross and Blue Shield
Quality Management Department

700 Broadway CO0104-0430
Denver, CO 80273
1-800-735-6072

Does this Coverage 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 Coverage Meet the Minimum Value Standard? 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:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíílkiid. Éí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.