City Of New Haven: Century Preferred Comp Mix $1000-$2000 FD:001116-024,053,059,203,270,492,496,504,513,517

Coverage Period: 07/01/2016 - 06/30/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual/Family | **Plan Type:** PPO

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 or by calling **800-233-4947**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,000** single / **$2,000** family for In-Network Provider **$2,000** single / **$4,000** family for Non-Network Provider Does not apply to In-Network Preventive Care, Office Visits, Outpatient Surgery, Walk-In Centers, Outpatient Rehabilitation Services, and Home Health Care	You must pay all the costs up to the **deductible** amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the **deductible** starts over (usually, but not always, January 1st.) See the chart starting on page 3 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 3 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes; In-Network Provider Single: **$3,000**, Family: **$6,000** Non-Network Provider Single: **$6,000**, Family: **$12,000**	The **out-of-pocket limit** is the most you could pay during a policy period 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?	Balance-Billed Charges, Copayments, Health Care This Plan Doesn't Cover, Premiums, Non-network inpatient facility coinsurance.	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. This policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits
Does this plan use a network of providers?	Yes. See **www.anthem.com** or call **800-233-4947** for a list of participating providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Plans use the terms in-network, preferred, or participating to refer to providers in their network.

Do I need a referral to see a specialist?	No, you do not need a referral to see a specialist.	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 7. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **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 30% would be $300. 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**.)
- This plan may encourage you to use **in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Partcipating Provider	Your Cost If You Use a Non-Partcipating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**$20** copay	40% Coinsurance after Deductible	Deductible waived for In-Network Providers.
	Specialist visit	**$20** copay	40% Coinsurance after Deductible	Deductible waived for In-Network Providers.
	Other practitioner office visit	Chiropractor **$20** copay	Chiropractor 40% Coinsurance after Deductible	Chiropractor: Deductible waived for In-Network Providers. Coverage is limited to 20 visits per year.
	Preventive care/screening/immunization	No Cost Share	40% Coinsurance after Deductible	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	**Lab - Office** **20%** Coinsurance after Deductible **X-Ray-Office** **20%** Coinsurance after Deductible	**Lab – Office** 40% Coinsurance after Deductible **X-Ray-Office** 40% Coinsurance after Deductible	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Partcipating Provider	Your Cost If You Use a Non-Partcipating Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	**$75** Copay	40% Coinsurance after Deductible	$375 copay maximum per member per calendar year. Failure to obtain preauthorization may result in non-coverage or reduced coverage.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.anthem.com	Tier 1 – Typically Generic	**$10** copay retail/**$10** copay mail order	20% coinsurance after Deductible	Covers up to a 30 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)
	Tier 2 – Typically Preferred/Formulary Brand	**$25** copay retail/ **$50** copay mail order	20% coinsurance after Deductible	Covers up to a 30 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)
	Tier 3 – Typically Non-preferred/ non-Formulary Drugs	**$40** copay retail/ **$80** copay mail order	20% coinsurance after Deductible	Covers up to a 30 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)
	Tier 4 – Typically Specialty Drugs	**$40** copay retail/ **$80** copay mail order	20% coinsurance after Deductible	Covers up to a 30 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**20%** Coinsurance after Deductible	40% Coinsurance after Deductible	**20%** Coinsurance after Deductible in **hospital** setting
	Physician/surgeon fees	**$20** Copay	40% Coinsurance after Deductible	Deductible waived for In-Network Providers.
If you need immediate medical attention	Emergency room services	**$100** Copay	**$100** Copay	Deductible waived for In-Network Providers. Copay waivd if admitted.
	Emergency medical transportation	**20%** Coinsurance after Deductible	**20%** Coinsurance after Deductible	——————none——————
	Urgent care	**$75** Copay	Not Covered	Deductible waived for In-Network Providers.
If you have a hospital stay	Facility fee (e.g., hospital room)	**20%** Coinsurance after Deductible	40% Coinsurance after Deductible	Failure to obtain preauthorization may result in non-coverage or reduced coverage.

Common Medical Event	Services You May Need	Your Cost If You Use a Partcipating Provider	Your Cost If You Use a Non-Partcipating Provider	Limitations & Exceptions
	Physician/surgeon fee	**$20** Copay	40% Coinsurance after Deductible	Deductible waived for In-Network Providers .
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Mental Health Office Visit **$20** copay Mental Health Facility Visit - Facility Charges No cost share	Mentel Health Office Visit 40% Coinsurance after Deductible Mental Health Facility Visit - Facility Charges 40% Coinsurance after Deductible	Deductible waived for in network providers
	Mental/Behavioral health inpatient services	**20%** Coinsurance after Deductible	40% Coinsurance after Deductible	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Substance use disorder outpatient services	Substance Abuse Office Visit **$20** copay Substance Abuse Facility Visit - Facility Charges No cost share	Substance Abuse Office Visit 40% Coinsurance after Deductible Substance Abuse Facility Visit - Facility Charges 40% Coinsurance after Deductible	Deductible waived for in network providers
	Substance use disorder inpatient services	**20%** Coinsurance after Deductible	40% Coinsurance after Deductible	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
If you are pregnant	Prenatal and postnatal care	**$20** copay	40% Coinsurance after Deductible	Copay applies to initial office visit only. Your doctor's charges for delivery are part of prenatal and postnatal care.
	Delivery and all inpatient services	**20%** Coinsurance after Deductible	40% Coinsurance after Deductible	

Common Medical Event	Services You May Need	Your Cost If You Use a Partcipating Provider	Your Cost If You Use a Non-Partcipating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	**20%** Coinsurance	20% Coinsurance	Coverage is 200 visits per member per calendar year. Deductible waived for both in and out of network providers.
	Rehabilitation services	**$20** Copay	40% Coinsurance after Deductible	Coverage is limited to 30 visits per year per Member, for Physical, Occupational, and Speech Therapy combined. Failure to obtain preauthorization may result in non-coverage or reduced coverage. Office and outpatient visits count towards your rehabilitation limit. Deductible waived for In-Network Providers.
	Habilitation services	**$20** Copay	40% Coinsurance after Deductible	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Skilled nursing care	**20%** Coinsurance after Deductible	40% Coinsurance after Deductible	Prior authorization is required for this service; without it, benefits may be reduced or denied. Coverage allows 120 days per calendar year.
	Durable medical equipment	**20%** Coinsurance after Deductible	40% Coinsurance after Deductible	——————none——————
	Hospice service	**20%** Coinsurance	20% Coinsurance	Deductible waived for both in and out of network providers.
If your child needs dental or eye care	Eye exam	No Cost Share	40% Coinsurance after Deductible	1 exam every 2 calendar years
	Glasses	Not Covered	Not Covered	——————none——————
	Dental check-up	Not Covered	Not Covered	——————none——————

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.)**

- Cosmetic surgery
- Dental care (adult)
- Long- term care
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide.
- Routine foot care Except in the case of vascular or systemic disease affecting the foot such as diabetes. Consult your formal contract of coverage for details.
- 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
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment Age and cycle limitations apply. Consult your formal contract of coverage for details.
- Private-duty nursing Coverage is limited to $50,000 per year. Consult your formal contract of coverage for details.
- Routine eye care (adult). Coverage is limited to every 24 months. Consult your certificate for details.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1-855-333-5735. You may also contact your state insurance department, the
Department of Labor's Employee Benefits
Security Administration
1-866-444-EBSA (3272) www.dol.gov/ebsa/healthreform.

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:

Anthem Blue Cross & Blue Shield
Appeals/Grievances
P.O. Box 1038
North Haven, CT 06473

Connecticut Insurance Department
P.O. Box 816
Hartford, CT 06142-0816
Consumer Helpline: (860) 297-3900
cid.ca@ct.gov

For ERISA information, please contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program can help you file your appeal. Contact:
Connecticut Office of the Healthcare Advocate www.ct.gov/oha healthcare.advocate@ct.gov
P.O. Box 1543 Hartford, CT 06144 (866) 466-4446

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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'éjíigo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíiłkiid. Eí 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.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,540
- **Patient pays** $1,000

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,000
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$1,000**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $5,300
- **Patient pays** $100

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$100
Coinsurance	$0
Limits or exclusions	$0
Total	**$100**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to **a** particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.