



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/](http://www.healthcare.gov/sbc-glossary/) or call (800) 735-6072 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>\$1,600</b> /single or <b>\$3,200</b> /family for <a href="#">In-Network Providers</a> . <b>\$3,200</b> /single or <b>\$6,400</b> /family for <a href="#">Out-of-Network 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 policy, the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> for <a href="#">In-Network 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 preventive services without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered preventive services 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> ?	<b>\$3,200</b> /single or <b>\$6,400</b> /family for <a href="#">In-Network Providers</a> . <b>\$6,400</b> /single or <b>\$12,800</b> /family for <a href="#">Out-of-Network 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> , the overall family <a href="#">out-of-pocket limit</a> must be met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Pre-Authorization Penalties, <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 you use a <a href="#">network provider</a> ?	Yes, PPO. See <a href="http://www.anthem.com/cuhealthplan">www.anthem.com/cuhealthplan</a> or call (800) 735-6072 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network 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 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
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's office</a> or clinic	Primary care visit to treat an injury or illness	15% <a href="#">coinsurance</a> after deductible	35% <a href="#">coinsurance</a> after deductible	-----none-----
	<a href="#">Specialist</a> visit	15% <a href="#">coinsurance</a> after deductible	35% <a href="#">coinsurance</a> after deductible	-----none-----
	<a href="#">Preventive care/screening/immunization</a>	\$0 /visit	35% <a href="#">coinsurance</a> 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 <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)	15% <a href="#">coinsurance</a> after deductible	35% <a href="#">coinsurance</a> after deductible	-----none-----
	Imaging (CT/PET scans, MRIs)	15% <a href="#">coinsurance</a> after deductible	35% <a href="#">coinsurance</a> 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 <a href="#">prescription drug coverage</a> under CVS's Standard Control Formulary with Advanced Control Specialty Formulary is available at <a href="https://info.caremark.com/acsdruglist">https://info.caremark.com/acsdruglist</a>	Tier 1 - Typically Generic	10% <a href="#">coinsurance</a> after deductible 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% <a href="#">coinsurance</a> after deductible for up to a 30-day supply	<b>Specialty RX:</b> 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.  <b>Maintenance medication:</b> 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 to a 90-day supply to be covered.
	Tier 2 - Typically Preferred Brand	20% <a href="#">coinsurance</a> after deductible 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% <a href="#">coinsurance</a> after deductible for up to a 30-day supply	

				<p><b>Generic Preventive Therapy Drugs:</b></p> <p>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</p> <p>CVS Caremark Customer Care: 1-888-964-0121</p>
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\* 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	20% <a href="#">coinsurance</a> after deductible 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% <a href="#">coinsurance</a> after deductible for up to a 30-day supply	<p><b>Diabetic Medication &amp; Supplies:</b> Members diagnosed with diabetes may be eligible to have insulin, <b>generic</b> diabetic medication, pumps &amp; supplies (needles, syringes, lancets, test strips) obtained at in network pharmacies with no applicable copayment (100% covered). Please contact member services for additional information.</p> <p>CVS Caremark Customer Care: 1-888-964-0121</p> <p>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.</p>
	Tier 4 - Typically <a href="#">Specialty Drugs</a>	20% <a href="#">coinsurance</a> after deductible 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% <a href="#">coinsurance</a> after deductible for up to a 30-day supply	

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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% <a href="#">coinsurance</a> after deductible	35% <a href="#">coinsurance</a> after deductible	Failure to obtain pre-authorization may result in reduced or no coverage.
	Physician/surgeon fees	15% <a href="#">coinsurance</a> after deductible	35% <a href="#">coinsurance</a> after deductible	-----none-----
If you need immediate medical attention	<a href="#">Emergency room care</a>	15% <a href="#">coinsurance</a> after deductible	Covered as <a href="#">In-Network</a>	There may be other levels of cost share that are contingent on how services are provided.
	<a href="#">Emergency medical transportation</a>	15% <a href="#">coinsurance</a> after deductible	Covered as <a href="#">In-Network</a>	-----none-----
	<a href="#">Urgent care</a>	15% <a href="#">coinsurance</a> after deductible	35% <a href="#">coinsurance</a> after deductible	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	15% <a href="#">coinsurance</a> after deductible	35% <a href="#">coinsurance</a> after deductible	Failure to obtain pre-authorization may result in reduced or no coverage.
	Physician/surgeon fees	15% <a href="#">coinsurance</a> after deductible	35% <a href="#">coinsurance</a> after deductible	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit 15% <a href="#">coinsurance</a> after deductible; Other Outpatient 15% <a href="#">coinsurance</a> after deductible	Office Visit 35% <a href="#">coinsurance</a> after deductible; Other Outpatient 35% <a href="#">coinsurance</a> after deductible	Failure to obtain pre-authorization may result in reduced or no coverage.
	Inpatient services	15% <a href="#">coinsurance</a> after deductible	35% <a href="#">coinsurance</a> after deductible	Failure to obtain pre-authorization may result in reduced or no coverage.
If you are pregnant	Office visits	15% <a href="#">coinsurance</a> after deductible	35% <a href="#">coinsurance</a> 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% <a href="#">coinsurance</a> after deductible	35% <a href="#">coinsurance</a> after deductible	
	Childbirth/delivery facility services	15% <a href="#">coinsurance</a> after deductible	35% <a href="#">coinsurance</a> after deductible	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	15% <a href="#">coinsurance</a> after deductible	35% <a href="#">coinsurance</a> after deductible	100 visits/calendar year combined for <a href="#">In-Network</a> and <a href="#">Out-of-Network</a> . Failure to obtain pre-authorization may result in reduced or no coverage.
	<a href="#">Rehabilitation services</a>	15% <a href="#">coinsurance</a> after deductible	35% <a href="#">coinsurance</a> 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)	
	<a href="#">Habilitation services</a>	15% <a href="#">coinsurance</a> after deductible	35% <a href="#">coinsurance</a> after deductible	limited to 40 visits each per plan year combined <a href="#">In-Network</a> and <a href="#">Out-of-Network</a> . All rehabilitation and habilitation visits count toward your rehabilitation visit limit.
	<a href="#">Skilled nursing care</a>	15% <a href="#">coinsurance</a> after deductible	35% <a href="#">coinsurance</a> after deductible	Failure to obtain pre-authorization may result in reduced or no coverage. Covers up to 100 days per plan year combined <a href="#">In-Network</a> and <a href="#">Out-of-Network</a> .
	<a href="#">Durable medical equipment</a>	15% <a href="#">coinsurance</a> after deductible	Not covered	Failure to obtain pre-authorization may result in reduced or no coverage. Includes 1 wig following cancer treatment.
	<a href="#">Hospice services</a>	15% <a href="#">coinsurance</a> after deductible	35% <a href="#">coinsurance</a> after deductible	Failure to obtain pre-authorization may result in reduced or no coverage.
<b>If your child needs dental or eye care</b>	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](#).)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Cosmetic surgery
- Dental care (adult)
- Long-term care
- Private-duty nursing
- Routine foot care unless you have been diagnosed with diabetes
- 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.
- Weight loss programs
- Routine vision exam

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

- Acupuncture (20 visit maximum)
- Bariatric surgery
- Chiropractic care (20 visit maximum)
- Most coverage provided outside the United States [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)
- Hearing Aids (1 pair/5 years)
- 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](http://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](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](#) 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](http://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.*—————



## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,600
■ <a href="#">Specialist coinsurance</a>	15%
■ Hospital (facility) <a href="#">coinsurance</a>	15%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,840</b>
In this example, Peg would pay:	
<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$1,600
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,686
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$3,286</b>

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,600
■ <a href="#">PCP coinsurance</a>	15%
■ Hospital (facility) <a href="#">coinsurance</a>	15%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$7,460</b>
In this example, Joe would pay:	
<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$1,600
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$879
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$2,479</b>

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,600
■ <a href="#">Specialist coinsurance</a>	15%
■ Hospital (facility) <a href="#">coinsurance</a>	15%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$2,010</b>
In this example, Mia would pay:	
<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$1,600
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$62
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,662</b>

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 (Bàsɔ̀ wùdù):** M̄ dyi dyi-diè-djè b̄é b̄édjé bá céè-djè nià ke dyí ní, ɔ̀ m̀ò nì dyí-b̄édjèin-djè b̄é m̀ ké gbo-kpá-kpá kè b̄ǎ kp̄ɔ̀ djé m̀ bídí-wùdùún b̀ó pídyi. B̄é m̀ ké wuɖu-zìin-nyò d̀ò gbo wùdù ke, d̀á (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 ဖုန်း (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 n̄ɔŋ thiëc nē ke de yā thorē, ke yin n̄ɔŋ loŋ bē yi kuony ku w̄er alēu bē ḡɛɛr yic yin ne thoŋ du ke cin wēu tāauē ke piny. Te k̄ɔr yin ba jam wēnē ran ye thok geryic, ke yin c̄ɔl (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 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 (800) 735-6072 تماس بگیرید.

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