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://eoc.anthem.com/eocdps/3HUTSMG09012019. 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 1-855-330-1103 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$4,000** person / **$8,000** family for Tier 1 In-Network Provider. **$6,650** person / **$13,300** family for Tier 2 In-Network Provider.	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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, Prescription Drugs, Preventive Care, Primary Care visit, Specialist, Urgent care, and Vision visit for Tier 1 and Tier 2 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?	Yes; **$7,500** person / **$15,000** family for Tier 1 In-Network Provider. **$7,500** person / **$15,000** family for Tier 2 In-Network Provider.	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?	Premiums, Balance-Billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they do not count toward the out-of-pocket limit.
Will you pay less if you use a	Yes. HMO Blue New England. See www.anthem.com or	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

* For more information about limitations and exceptions, see the **plan** or policy document at https://eoc.anthem.com/eocdps/3HUTSMG09012019.

Important Questions	Answers	Why This Matters:
network provider?	call 1-855-330-1103 for a list of network providers.	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?	Yes.	This **plan** will pay some or all of the costs to see a **specialist** for covered services but only if you have a **referral** before you see the **specialist**.

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
		Tier 1 In-Network Preferred Provider (You will pay the least)	Tier 2 In-Network Provider (You will pay more)	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	$40/visit deductible does not apply	$60/visit deductible does not apply	Not covered	------none------
	Specialist visit	$80/visit deductible does not apply	$80/visit deductible does not apply	Not covered	------none------
	Preventive care/**screening**/immunization	No charge	No charge	Not covered	Prescribed FDA approved contraceptives are not subject to cost-shares. You may have to pay for services that aren't preventive. Ask your **provider** if the services you need are preventive. Then check what your **plan** will pay for.
If you have a test	**Diagnostic test** (x-ray, blood work)	20% coinsurance	25% coinsurance	Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	20% coinsurance	25% coinsurance	Not covered	------none------
If you need drugs to treat your illness or condition	Tier 1a - Typically Lower Cost Generic	$3 / prescription deductible does not apply (retail) and $8 / prescription deductible does not	$3 / prescription deductible does not apply (retail) and $8 / prescription deductible does not apply (home delivery)	Not covered	

* For more information about limitations and exceptions, see the **plan** or policy document at https://eoc.anthem.com/eocdps/3HUTSMG09012019.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 In-Network Preferred Provider (You will pay the least)	Tier 2 In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
More information about **prescription drug coverage** is available at http://www.anthem.com/pharmacyinformation/ Anthem Select Drug List		apply (home delivery)			*See **Prescription drug** section.
	Tier 1b - Typically Generic	$25 / prescription deductible does not apply (retail) and $63 / prescription deductible does not apply (home delivery)	$25 / prescription deductible does not apply (retail) and $63 / prescription deductible does not apply (home delivery)	Not covered	
	Tier 2 - Typically Preferred Brand & Non-Preferred Generics	$50 or 30% coinsurance, whichever is greater up to $300 / prescription deductible does not apply (retail) and $150 or 30% coinsurance, whichever is greater up to $900 deductible does not apply (home delivery)	$50 or 30% coinsurance, whichever is greater up to $300 / prescription deductible does not apply (retail) and $150 or 30% coinsurance, whichever is greater up to $900 deductible does not apply (home delivery)	Not covered	
	Tier 3 - Typically non Preferred Brand	$80 copay or 30% coinsurance, whichever is greater up to $300 per prescription deductible does not apply (retail only) and $240 copay or 30% coinsurance, whichever is greater up to $900 deductible does not	$80 copay or 30% coinsurance, whichever is greater up to $300 per prescription deductible does not apply (retail only) and $240 copay or 30% coinsurance, whichever is greater up to $900 deductible	Not covered	

* For more information about limitations and exceptions, see the **plan** or policy document at https://eoc.anthem.com/eocdps/3HUTSMG09012019.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 In-Network Preferred Provider (You will pay the least)	Tier 2 In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
		apply (home delivery only)	does not apply (home delivery only)		
	Tier 4 - Typically Specialty (brand and generic)	30% coinsurance up to $500 per prescription (retail and home delivery) deductible does not apply	30% coinsurance up to $500 per prescription (retail and home delivery) deductible does not apply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250/visit deductible does not apply	$250/visit deductible does not apply	Not covered	Costs may vary by site of service.
	Physician/surgeon fees	20% coinsurance	25% coinsurance	Not covered	Costs may vary by site of service.
If you need immediate medical attention	**Emergency room care**	$300 copay/visit and then 0% coinsurance	$300 copay/visit and then 0% coinsurance	$300 copay/visit and then 0% coinsurance	Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	--------none--------
	Urgent care	$100 copay/visit deductible does not apply	$100 copay/visit deductible does not apply	$100 copay/visit deductible does not apply	Costs may vary by site of service.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	25% coinsurance	Not covered	Coverage for Tier 1 **In-Network** and Tier 2 **In-Network Providers** is limited to 100 days per benefit period for Inpatient physical medicine and rehabilitation including day rehabilitation programs.
	Physician/surgeon fee	20% coinsurance	25% coinsurance	Not covered	--------none--------
If you need mental health, behavioral health, or	Outpatient services	Office Visit $40/visit deductible does not apply Other Outpatient 20% coinsurance	Office Visit $40/visit deductible does not apply Other Outpatient 25% coinsurance	Office Visit Not covered Other Outpatient Not covered	Office Visit --------none-------- Other Outpatient --------none--------

* For more information about limitations and exceptions, see the **plan** or policy document at https://eoc.anthem.com/eocdps/3HUTSMG09012019.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 In-Network Preferred Provider (You will pay the least)	Tier 2 In-Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
substance abuse needs	Inpatient services	20% coinsurance	20% coinsurance	Not covered	--------none--------
If you are pregnant	Office visits	20% coinsurance	25% coinsurance	Not covered	In-Network preventive services, routine prenatal office visits and other preventive prenatal care and screenings are covered at 100%. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Postpartum office visits are part of the professional maternity services.
	Childbirth/delivery professional services	20% coinsurance	25% coinsurance	Not covered	
	Childbirth/delivery facility services	20% coinsurance	25% coinsurance	Not covered	
If you need help recovering or have other special health needs	**Home health care**	20% coinsurance	20% coinsurance	Not covered	--------none--------
	Rehabilitation services	$40 copay/visit deductible does not apply	$40 copay/visit deductible does not apply	Not covered	*See Therapy Services section.
	Habilitation services	$40 copay/visit deductible does not apply	$40 copay/visit deductible does not apply	Not covered	
	Skilled nursing care	20% coinsurance	20% coinsurance	Not covered	Coverage for Tier 1 **In-Network** and Tier 2 **In-Network Providers** is limited to 100 days per benefit period.
	Durable medical equipment	20% coinsurance	20% coinsurance	Not covered	*See Durable Medical Equipment section
	Hospice service	0% coinsurance	0% coinsurance	Not covered	--------none--------
If your child needs dental or eye care	Eye exam	No charge	No charge	Not covered	*See Vision Services section.
	Glasses	No charge	No charge	Not covered	
	Dental check-up	0% coinsurance	0% coinsurance	Not covered	*See Dental Services section.

* For more information about limitations and exceptions, see the **plan** or policy document at https://eoc.anthem.com/eocdps/3HUTSMG09012019.

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
- Non-emergency care when traveling outside the U.S
- Routine foot care
- Dental care (adult)
- Non-Formulary drugs
- Weight loss programs
- Long-term care
- Routine foot care

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

- Abortion
- Chiropractic care
- Routine eye care (Adult) 1 exam / benefit period.
- Acupuncture 12 visits/benefit period.
- Hearing aids
- Bariatric Surgery
- 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 1-866-444-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: Anthem **Grievance**s and **Appeals**, P.O. Box 518, North Haven, CT 06473-0518-0518

Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform

New Hampshire Insurance Department 21 So Fruit St Suite 14, Concord, NH 03301 Consumer Hotline (800) 852-3416

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**.

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 plan's overall deductible	$4,000
Specialist copayment	$80
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$4,000
Copayments	$200
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,760**

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

The plan's overall deductible	$4,000
Specialist copayment	$80
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$100
Copayments	$1,300
Coinsurance	$1,600
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,060**

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

The plan's overall deductible	$4,000
Specialist copayment	$80
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$1,100
Copayments	$400
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,800**

Language Access Services:

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 (855) 330-1103

Amharic (አማርኛ)፦ ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 330-1103 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 (855) 330-1103.

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՝ (855) 330-1103:

Bassa (Bǎsɔ́ɔ̀ Wùdù): M̀ dyi dyi-diè-dɛ̀ bě bédé bá céè-dɛ̀ nìà kɛ dyí ní, ɔ mɔ̀ nì dyí-bɛ̀dɛ̀ìn-dɛ̀ bɛ́ m̀ ké gbo-kpá-kpá kè bɔ̌ kpɔ̃ dé m̀ bídí-wùdùǔn bó pídyi. Bé m̀ ké wudu-zììn-nyɔ̀ dò gbo wùdù kɛ, dá (855) 330-1103.

Bengali (বাংলা)**:** যদি এই তথ্য পুস্তিকার বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য কল করুন (855) 330-1103

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အခမဲ့အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (855) 330-1103 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 (855) 330-1103。

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 (855) 330-1103.

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 (855) 330-1103.

Farsi (فارسي)**:** در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (855) 330-1103 تماس بگیرید.

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 (855) 330-1103.

Language Access Services:

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 (855) 330-1103.

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 (855) 330-1103.

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 (855) 330-1103.

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 (855) 330-1103.

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 (855) 330-1103 ।

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 (855) 330-1103.

Igbo (Igbo): Ọ bụr ụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (855) 330-1103.

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 (855) 330-1103.

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 (855) 330-1103.

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 (855) 330-1103

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、(855) 330-1103 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ (855) 330-1103 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (855) 330-1103.

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Lao (ພາສາລາວ): ຖ້າທ່ານມີຄຳຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອໂອ້ລົມກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ (855) 330-1103.

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Nepali (नेपाली): यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ। दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (855) 330-1103

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