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: July 1st, 2016 – June 30th, 2017 For in-network: **$240** per individual or 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 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**: **$2,400** Single/**$7,200** Family Family **out-of-pocket** limit can be met by any one member of the family or can be met if multiple family members collectively meet the **out-of-pocket** limit.	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 5. 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 under Anthem's Preferred Formulary** is available at www.anthem.com/cuhealthplan	Tier 1 Generic drugs	20% coinsurance after deductible for up to a 90-day supply at Retail or Mail Order	**Specialty RX:** Per fill, a maximum of up to 30 days of Specialty medication. **Diabetic Medication & Supplies:** Members diagnosed with diabetes may be eligible to have diabetic medication & supplies obtained at in network pharmacies with no applicable coinsurance (100% covered). Please contact member services for additional information. For a complete listing of Retail Pharmacy locations, please use the following link: www.anthem.com/cuhealthplan.
	Tier 2 Preferred brand drugs	20% coinsurance after deductible for up to a 90-day supply at Retail or Mail Order	
	Tier 3 Non-preferred brand drugs	20% coinsurance after deductible for up to a 90-day supply at Retail or Mail Order	
	Tier 4 Specialty Orals and Injectable drugs	20% coinsurance after deductible for up to a 30-day supply at Retail or Mail Order	
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.
If you need immediate medical attention	Emergency room services	20% coinsurance after deductible	Contact your Primary Care Provider (PCP) within 48 hours. Coverage for Medicare-approved charges not reimbursed by Medicare.
	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.
	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.)

- Bartiatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- 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

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

Questions: Call **1-800-735-6072** or visit us at www.anthem.com/cuhealthplan
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.anthem.com/cuhealthplan or call **1-800-735-6072** to request a copy.

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

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'éjíígo, 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.