



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 <u>deductible</u> ? | Plan Year Deductible: July 1 st , 2022 – June 30 th , 2023 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 <u>deductible</u> 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 <u>deductible</u> . |
| Are there other <u>deductibles</u> for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| Is there an <u>out-of-pocket limit</u> on my expenses? | Yes. For <u>in-network</u> : \$2,400 Single/ \$7,200 Family | The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> ? | Premiums, balance-billed charges and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |

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| | | |
|---|------|---|
| Is there an overall annual limit on what the plan pays? | No. | The chart starting on page 2 describes <i>specific</i> coverage limits, such as limits on the number of office visits. |
| Do I need a referral to see a <u>specialist</u> ? | No. | You can see the <u>specialist</u> 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 <u>excluded services</u> . |



- **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 <u>provider's</u> 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. |

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| 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 CVS's Standard Control Formulary with Advanced Control Specialty Formulary is available at https://info.caremark.com/acsdruglist | 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 customer service for additional information. |
| | 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 | 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. |

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| Common Medical Event | Services You May Need | Your Cost | Limitations & Exceptions |
|-------------------------------------|-----------------------|----------------------------------|--|
| If you have a hospital stay (cont.) | Physician/surgeon fee | 20% coinsurance after deductible | Coverage for Medicare-approved charges not reimbursed by Medicare. |

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| 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 | 1 st – 20 th day – No charge, Medicare pays 100%. 21 st – 100 th 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. |

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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

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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 adoolwoł iínizinigo t'áá diné k'éjígó, t'áá shoodí ba na'alníhí ya sidáhí bich'í naabídíłkiid. Eí doo biigha daago ni ba'nija'go ho'aalagú bich'í hodiilní. Hai'daa iini'taago eíya, t'áá shoodí diné ya atáh halne'ígú ní béesh bee hane'í wólta' bi'ki si'niilígú bi'kéhgo bich'í hodiilní.

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