



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/9P9DIND01012024>. 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 (855) 738-6644 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$2,000/person or \$4,000/family for In- Network Providers . \$4,000/person or \$8,000/family for Non- Network Providers .	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. Preventive Care . Certain Prescription Drugs . For more information see below.	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?	Yes. \$50/person for Home Health care. There are no other specific deductibles .	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	\$9,000/person or \$18,000/family for In- Network Providers . \$18,000/person or \$36,000/family for Non- Network Providers .	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-billing 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 .
Will you pay less if you use a network provider?	Yes. See www.anthem.com/find-care/?alphaprefix=VHA or call (855) 738-6644 for a list of network providers . Costs may vary by site of service and how the provider bills.	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 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 ?	No.	You can see the specialist you choose without a referral .
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 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 provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	50% coinsurance	Virtual visits (Telehealth) benefits available.
	Specialist visit	10% coinsurance	50% coinsurance	Virtual visits (Telehealth) benefits available.
	Preventive care / screening /immunization	No charge	50% coinsurance deductible does not apply	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	50% coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)	10% coinsurance	50% coinsurance	-----none-----
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.anthem.com/pharmacyinformation/	Typically Generic (Tier 1)	10% coinsurance , deductible does not apply (retail and home delivery)	50% coinsurance (retail and home delivery)	For more information, refer to "Select Drug List" at http://www.anthem.com/pharmacyinformation/ *See Prescription Drug section
	Typically Preferred Brand (Tier 2)	20% coinsurance , deductible does not apply (retail and home delivery)	50% coinsurance (retail and home delivery)	
	Typically Non-Preferred Brand and Generic drugs (Tier 3)	20% coinsurance up to \$500/prescription, deductible does not apply (retail) and 20% coinsurance , deductible does not apply (home delivery)	50% coinsurance (retail and home delivery)	
	Typically Preferred Specialty (brand and generic) (Tier 4)	20% coinsurance up to \$1,000/prescription (retail and home delivery)	50% coinsurance (retail and home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	50% coinsurance	-----none-----
	Physician/surgeon fees	10% coinsurance	50% coinsurance	-----none-----
If you need	Emergency room care	10% coinsurance	Covered as In- Network	-----none-----

* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://eoc.anthem.com/eocdps/9P9DIND01012024>.

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)	
immediate medical attention	Emergency medical transportation	10% coinsurance	Covered as In- Network	Non-emergency non- network Ambulance Services are limited to \$50,000 per occurrence.
	Urgent care	10% coinsurance	50% coinsurance	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	50% coinsurance	-----none-----
	Physician/surgeon fees	10% coinsurance	50% coinsurance	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit 10% coinsurance Other Outpatient 10% coinsurance	Office Visit 50% coinsurance Other Outpatient 50% coinsurance	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient -----none-----
		Inpatient services	10% coinsurance	50% coinsurance
	Office visits	No charge	50% coinsurance	Cost sharing does not apply for preventive services . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
If you are pregnant	Childbirth/delivery professional services	10% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	50% coinsurance	
	Home health care	10% coinsurance , Home Health Care deductible applies	25% coinsurance , Home Health Care deductible applies	100 visits/year.
If you need help recovering or have other special health needs	Rehabilitation services	10% coinsurance	50% coinsurance	*See Therapy Services section.
	Habilitation services	10% coinsurance	50% coinsurance	
	Skilled nursing care	10% coinsurance	50% coinsurance	90 days/year for skilled nursing services.
	Durable medical equipment	10% coinsurance	50% coinsurance	*See Durable Medical Equipment Section
	Hospice services	10% coinsurance	50% coinsurance	
	-----none-----			
If your child needs dental or eye care	Children's eye exam	\$40/visit	50% coinsurance	*See Vision Services section
	Children's glasses	\$0/unit	50% coinsurance	
	Children's dental check-up	No charge	No charge	*See Dental Services section

* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://eoc.anthem.com/eocdps/9P9DIND01012024>.

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)
- Dental care (Adult)
- Private-duty nursing
- Weight loss programs
- Bariatric surgery
- Long-term care
- Routine eye care (Adult)
- Cosmetic surgery
- Non-emergency care when traveling outside the U.S.
- Routine foot care unless medically necessary

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

- Acupuncture Coverage is limited to Pain Management
- Infertility treatment
- Chiropractic care 20 visits/year
- Hearing aids

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: Connecticut Department of Insurance, 153 Market Street, 7th Floor, Hartford, CT 06103, (860) 297-3000, (800) 203-3447, or contact Anthem at the number on the back of your ID card. 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 on how 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, P.O. Box 1038, North Haven, CT 06473-4201

Connecticut Department of Insurance, 153 Market Street, 7th Floor, Hartford, CT 06103, (860) 297-3000, (800) 203-3447

Connecticut Office of Healthcare Advocate, P.O. Box 1543, Hartford, CT 06144, (866) 466-4446, www.ct.gov/oha, healthcare.advocate@ct.gov

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? Not Applicable

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](#).

* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/9P9DIND01012024>.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://eoc.anthem.com/eocdps/9P9DIND01012024>.

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](#)
- [Specialist coinsurance](#)
- Hospital (facility) [coinsurance](#)
- Other [coinsurance](#)

\$2,000
10%
10%
10%

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

\$12,700

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$0
Coinsurance	\$1,100

What isn't covered

Limits or exclusions	\$60
The total Peg would pay is	\$3,160

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#)
- [Specialist coinsurance](#)
- Hospital (facility) [coinsurance](#)
- Other [coinsurance](#)

\$2,000
10%
10%
10%

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

\$5,600

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,100
Copayments	\$0
Coinsurance	\$800

What isn't covered

Limits or exclusions	\$20
The total Joe would pay is	\$1,920

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#)
- [Specialist coinsurance](#)
- Hospital (facility) [coinsurance](#)
- Other [coinsurance](#)

\$2,000
10%
10%
10%

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

\$2,800

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$0
Coinsurance	\$80

What isn't covered

Limits or exclusions	\$0
The total Mia would pay is	\$2,080

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Language Access 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) 738-6644

Amharic (አማርኛ): ለአዲስ ሌሎች ማንኛውም ቅያች ካለዋቸው በፈላጊው ቅንቃ እርዳታ እና ይህን መረጃ በለዕስ የሚገኘት መብት አለዋቸው፡፡ አስተርጓሚ ለማናገድ (855) 738-6644 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 738-6644 (855).

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) 738-6644։

Bassa (Basa Wùqdù): M dyi dyi-diè-dè bë bédé bá céè-dè nià ke dyí ní, o mò nì dyí-bèdèin-dè bë mì kék gbo-kpá-kpá kë bë kpë qé mì bídí-wùqdùún bò pídyi. Bé mì kék wuqu-zììn-nyò dò gbo wùqdù ke, qá (855) 738-6644.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্য সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাসীর সাথে কথা খান জন্য (855) 738-6644 -তে কল করুন।

Burmese (မြန်မာ): ဤတရုပ်တတ်မှုနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကုအညီကို အကြောင်းငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားမြန် တစ်ဦးနှင့် စကားမြန်ရန် ဖူး (855) 738-6644 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) 738-6644。

Dinka (Dinka): Na nəj thiēec nē ke de yā thorē, ke yin nəj loj bē yi kuony ku wer alēu bē gēer yic yin ne thoj du ke cin wēu tāāuē ke piny. Te kər yin ba jam wēnē ran ye thok geryic, ke yin cəl (855) 738-6644.

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) 738-6644.

Farsi (فارسی) : 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) 738-6644 تماس بگیرید.

Language Access Services:

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) 738-6644.

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) 738-6644.

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) 738-6644.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નનો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહત્ત્મિ મેળવવાનો તમને અધકિક છે. દુભાષયા સાથે વાત કરવા માટે, કોણ કરો (855) 738-6644.

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) 738-6644.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज 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) 738-6644 |

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) 738-6644.

Igbo (Igbo): O bụr ụ na i nwere ajụjụ ọ bụla gbasara akwụkwọ a, i nwere ike i nweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkowa okwu kwuo okwu, kpọọ (855) 738-6644.

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) 738-6644.

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) 738-6644.

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) 738-6644

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) 738-6644 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ): បើមុកមានសំណូរឡើងទៅគម្រោគសារនេះ មុកមានសិទ្ធិទន្លេលដែនូយនិងកំមានជាការបស់មុកដោយគគិតគ្នា។ ធីមីជិតដែកជាមុកបាបការប្រព័ន្ធមូលដ្ឋាន (855) 738-6644 ១

Kirundi (Kirundi): Ugeze ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (855) 738-6644.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(855) 738-6644 로 문의하십시오.

Lao (ພາສາລາວ): ທ່ານມີຄໍາຖາມໃດໆກ່ອນກັບພາກສານນີ້, ທ່ານມີສິດໄດ້ກັບຄວາມຮ່ວມມື້ນ ແລະ ຂໍມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ແລ້ວ. ເພື່ອໄຫວ້ມີກັບໜ້າ (855) 738-6644.

Navajo (Diné): Díí naaltsoos biká'ígíí ɬahgo bina'ídílkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee níl hodoonih t'áadoo bázh ilníg óó. Ata' halne'ígíí ɬa' bich'í' hadeesdzih nínízingo kojí' hodíílnih (855) 738-6644.

Nepali (नेपाली): यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ। दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस (855) 738-6644

Oromo (Oromifaa): Sanadi kanaa wajiiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeefanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (855) 738-6644 bilbilla.

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Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ (855) 738-6644 ਤੇ ਕਾਲ ਕਰੋ।

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