COLLECTIVE BARGAINING AGREEMENT

By and Between

SEYMOUR BOARD OF EDUCATION

and the

UPSEU

UNITED PUBLIC SERVICE EMPLOYEES UNION
LOCAL 424-UNIT 93
SEYMOUR BOE SCHOOL NURSES

July 1, 2022 to June 30, 2026

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ARTICLE 1
RECOGNITION

This Agreement, between the Seymour Board of Education (hereinafter called the "Board") and UPSEU Local 424, Unit 93 Seymour BOE Nurses, (hereinafter called the "UPSEU"), which the Board recognizes as the exclusive bargaining representative for all School Nurses (hereinafter "Nurses") in the Seymour Schools in accordance with Municipal Employee Relations Act under Case #ME-31,410.

ARTICLE 2
BOARD RIGHTS

The Board shall continue to retain its rights, powers and authorities so vested by law, unless specifically limited by the express provisions of this Agreement. Except where such rights, powers and authority are specifically relinquished, abridged or limited by the provisions of this Agreement, the Board has and will continue to retain, whether exercised or not, all of the rights, powers and authority, whether express or implied, heretofore had by it and, except where such rights, powers and authority are specifically relinquished, abridged or limited by the provisions of this Agreement, it shall have the sole and unquestioned right, responsibility and prerogative of the management of the affairs of the school and direction of the working force.

a. **Enumerated Rights:** The exclusive functions and rights of the Board include, but are not restricted to, the right to establish or continue policies, practices and procedures for the conduct of Board business and, from time to time, to change or abolish such policies, practices or procedures; to direct the operation of the nurses in all aspects; to determine the methods and levels of financing and budget allocation; to determine and, from time-to-time, redetermine the number of nurses to be employed; to employ, promote, demote, transfer, layoff or otherwise relieve nurses from duty for lack of work or other legitimate reasons; to assign work; to determine shifts, work schedules and hours of work; to discipline, suspend and/or discharge nurses for just cause; to determine the procedures for promotions and transfers; to select and determine the qualifications of nurses; to select and employ new nurses; to determine job descriptions and job classifications; to create, enforce and, from time-to-time, change rules and regulations concerning discipline and the performance of work. Where any change in policy, past practice or procedure involves any impact on wages, hours or work conditions, the Board shall notify the Union and negotiate to the extent required by the Municipal Employees Relations Act.

b. **Unenumerated Rights:** The listing of specific rights in Section (a) of this provision is not intended to be all inclusive, restrictive or a waiver of any rights of the Board not listed which have not been expressly and specifically surrendered

ARTICLE 3
UNION DUES/SERVICE FEES DUES CHECK-OFF

a. UPSEU dues or service fees shall be deducted by the Board from the paycheck of each Nurse who signs and remits to the Board an authorization form. Such deduction shall be

discontinued upon written request of a Nurse filed with the Board fifteen (15) days in advance. UPSEU shall be notified within seven (7) business days.

b. The Board shall provide the UPSEU Labor Representative the following information in writing within ten (10) days of the date of hire: 1. full name; 2. work classification; 3. work location/department; 4. pay rate; 5. work email address; 6. employee mailing address; 7. work telephone; 8. home address; and 9. hire date.

c. The amount of dues or agency service fee deducted under this provision, together with a list of Nurses, shall be remitted to UPSEU in the month in which such deductions are made together with a list of Nurses and their addresses for whom any such deductions are made.

d. The UPSEU shall indemnify the Board for any liability or damages incurred by the employer in compliance with these provisions.

ARTICLE 4
WORKYEAR

The work year shall be in accordance with the school year established for the Seymour School System. The work year may include additional in-service days for employees, for which the employees shall be provided advance notice. Nurses may be scheduled to work additional days immediately before or after the student school year. Each employee will be given at least two (2) weeks' advance notice of the date of his/her last workday of each school year.

ARTICLE 5
HOURS OF WORK

Section 1: The Nurse's normal workday shall be defined as fifteen (15) minutes before the normal start of the school day and ends fifteen (15) minutes after the normal school day, which currently provides for a seven (7) hour workday to include a one-half hour paid lunch period. The Board will maintain the right to modify the length of the school day and implement such modification at its discretion, but if such change results in a change in the seven (7) hour workday, the Board will negotiate the impact of such change with the Union, with the result of such negotiations to be applied retroactively to the time of implementation. In a school with more than one Nurse, the building administrator may stagger the start of the workday, based on the needs of the school, after consultation with the Nurses at that school.

Section 2: Nurses, as professionals, will remain in their schools long enough after classes are dismissed to fulfill their professional demands, which may include individual help to students.

Section 3: The normal employment year shall be defined as 188 days. Work beyond the normal employment year or day shall be paid at the nurses' regular hourly rate, except as provided in Section 5 below. Prior permission is required from the building administrator to work in excess of the regularly scheduled work year or day. In a school with more than one Nurse, the building administrator may stagger the start of the work year, based on the needs of the school after consultation with the nurses.

Section 4: Nurses' workdays will include a one-half (1/2) hour paid lunch period.

Section 5: Any member of the Union who is required to perform nursing duties before or after their regularly scheduled hours shall be paid at their regular hourly rate of pay up to 40 hours in any workweek. Any work beyond a Nurse's regularly scheduled hours must be approved by the building administrator. All work beyond 40 hours in any workweek shall be paid at one and one-half times the Nurse's regular hourly rate of pay.

ARTICLE 6
EMPLOYMENT

Section 1: Notice of Vacancies, New Positions and Transfers
Notice of bargaining unit vacancies and/or new positions shall be posted in all schools and on the district website for ten (10) workdays.

a. Nurses who wish to apply for a vacancy or new position (additional nurse), or to transfer to another position, shall file a written statement of such desire with the Superintendent or his/her designee within the time limit provided.

b. When a position becomes available, present nurses will be given the opportunity to apply for a transfer to the open position first before hiring from the outside to fill a vacant position.

c. Where two or more nurses apply for the same position, the position shall be filled by the most senior nurse.

Section 2: Seniority

a. A Seniority list will be created each year as of October 1st, with a copy provided to the Union President and UPSEU Representative no later than October 15th.

b. Seniority is defined as the Nurse's continuing and uninterrupted length of service to the Board from the Nurse's most recent date of hire in the bargaining unit.

c. Any objection to the seniority list shall be reported to the Superintendent within ten (10) workdays of the seniority list being provided to the Union President and UPSEU Representative. Absent a timely objection, the seniority list shall be considered approved by the Parties. Any bona fide errors will be remedied.

Section 3: Lay-off and Recall

a. If the Board deems that layoffs are necessary, the least senior member of the bargaining unit shall be laid off first.

b. The most senior of the Nurses shall be recalled first. Nurses shall have recall rights for eighteen (18) months from date of lay-off.

c. Any Nurse being recalled from lay-off under this Section shall retain previous seniority.

d. Notice of recall will be sent by certified mail and email to the last address provided to the Board by the Nurse.

e. In the event a Nurse refuses to return to work when recalled or fails to respond to an offer of recall within ten (10) business days from the date of receipt of the notice of recall, his/her seniority will be considered lost and he/she will no longer be considered eligible for recall.

ARTICLE 7
COMPENSATION

Section 1: Pay Rate - All nurses will be paid for hours worked in accordance with the wage schedules contained in Appendix A, Wage Schedule.

Section 2: Pay Date and Direct Deposit to nurses shall be paid bi-weekly on Friday and shall be given an electronic copy of their bi-weekly payroll information. A payroll schedule will be provided to each Nurse by September 1st of each year. Nurses will receive their projected annual salaries and stipends in 26 approximately equal installments over the course of the year, with adjustments made in each pay period for any extra time worked as documented on the Nurses' timesheets.

The Board agrees to provide "Electronic Money Transfers" in the following capacities:

a. It will be mandatory for all employees to request, in writing, for the Board to credit to such employee's account all salary and wages in any bank which has agreed to directly accept direct wage deposits.

b. The Board will transmit monies to such agents of record each pay period.

ARTICLE 8
VACATION, HOLIDAY AND OTHER ABSENCES

Section 1: Sick Days

a. Fifteen (15) days shall be allowed annually with full pay for absence due to illness of the employee, cumulative to one hundred fifty-five (155) workdays. Up to five (5) days of the fifteen (15) sick days per year may be used to provide care for the illness of a family member of the employee's household. During the first year of employment, new employees shall receive a pro-rated number of sick days, based on the number of months remaining in the work year following their first day of work.

b. Sick days may not be used to lengthen vacations or holidays.

c. If an employee's absence exceeds five (5) consecutive workdays, it shall be the responsibility of the employee to provide the Superintendent or his/her designee with a doctor's certificate verifying the medical need for the absence.

1. The Superintendent or his/her designee may request an acceptable medical certificate from an employee for any leave of any duration if absence from work occurs frequently, habitually, or in a pattern. In such case, the Superintendent/designee will provide the employee and the Union President with a written notice that the employee has been designated as a potential sick leave abuser.

2. When required to provide a medical certificate, the employee may provide a certificate from a doctor of his/her choosing, in which case the employee shall pay the cost. If the Superintendent requires a certificate from a doctor chosen by the Board, the Board shall pay the cost.

Section 2: Excused Absences
Five (5) days shall be allowed annually, with full pay, for personal business as defined in the excused absence form. Such days are in addition to sick days. Unused days cannot be accrued.

Section 3: Professional Days
Two (2) days shall be granted annually, with full pay, for attendance at professional conferences. Attendance must be approved by the Superintendent in advance, which shall not be unreasonably denied.

Section 4: Delayed Opening
On delayed opening days, nurses are expected to make every effort to report to work and shall suffer no loss of pay or leave time, if the Nurse reports for that day by the time school opens.

Section 5: Unplanned Early Dismissals and School Closings
a. On unplanned early dismissal days, Nurses are expected to remain on duty until fifteen (15) minutes after students leave the school, except in cases of medical emergencies.

b. On school closings for inclement weather and other emergency closings, nurses are not expected to report to work and shall suffer no loss of pay.

Section 6: Bereavement Leave
Employees shall be granted up to five (5) working days of leave immediately following a death in the household of the immediate family, specifically a spouse, significant other, child, parent, parent-in-law, sibling or stepchild. One (1) day will be provided for grandparents, aunts and uncles.

Section 7: Paid Holidays
a. Nurses shall annually receive a full day's pay for the following holidays:

1. Thanksgiving
2. Christmas
3. New Year's Day
4. Martin Luther King Day
5. Memorial Day
6. Columbus Day

7. Presidents' Day
8. Good Friday
9. Election Day
10. Labor Day
11. Day after Thanksgiving

Members will receive Juneteenth as a paid holiday, in the event that the Board of Education ever votes to approve the day as a holiday for the District.

The Board agrees that payment for the holiday shall be included with the equalized wages paid throughout the year.

Section 8: Maternity Leave
Disabilities caused by pregnancy, miscarriage, childbirth, and recovery there from, shall be treated as temporary disabilities for all job-related purposes. Accumulated sick leave shall be available for use during periods of such disability. Pregnancy or childbirth shall not be the basis for termination of employment or compulsory resignation. The Board reserves the right to obtain proper medical certification regarding the beginning and termination of such leave and may require examination or consultation by the School Medical Officer. The Board will continue to pay its share of insurance costs during the period of disability.

Section 9: Child Rearing Leave
Employees shall be granted child rearing leave in accordance with the Family Medical Leave Act (FMLA).

Section 10: Jury Duty
Jury duty will be provided in accordance with State Statutes.

ARTICLE 9
FRINGE BENEFITS/CLOTHING

Section 1: Life Insurance
Nurses working 20 or more hours per week will be provided with group term life insurance coverage (subject to insurance carrier age restrictions) in the amount of $25,000 with the full premium paid by the Board. Nurses will, at their own expense, be allowed to purchase up to an additional $100,000 in coverage, if allowed by the insurance carrier, by authorizing a payroll deduction for payment of such additional premiums. This benefit will terminate upon the employee's cessation of employment with the Board.

Section 2: Health Insurance
A High Deductible Health Plan ("HDHP") with Health Savings Account ("HSA") Plan ("HDHP/HSA") for nurses and eligible dependents.

From the plan year beginning July 1, 2022 through June 30, 2023, the Board will provide a HDHP/HSA which shall have an annual deductible of $2,000 individual and $4,000 family for in-network and out-of-network services. Effective July 1, 2023, the deductibles shall thereafter increase to $2,250 individual and $4,500 family. The combined in-network out-of-pocket annual

maximum shall be $5,000 individual and $6,850 family coverage. The combined out-of-network out-of-pocket annual maximum shall be $5,000 for individual coverage and $10,000 for family coverage. Once the deductible is met, the plan will pay 100% for in-network services. Out-of-network services shall be subject to an 80%/20% coinsurance.

Prescription co-pays of $5 for generic drugs, $25 for listed brand name drugs, and $40 for non-listed brand name drugs made after the annual deductible is satisfied will count towards the out-of-pocket maximum. A summary listing of benefits is provided in Appendix B.

A Health Savings Account (HSA) shall be established by the Board for each eligible Nurse who elects HDHP/HSA coverage. The Board shall annual, in July of each year, contribute by direct deposit to the Nurse's HSA (or HRA for active employees not eligible for an HSA) thirty percent (30%) of the in-network annual deductible.

The plan year for the HDHP/HSA plan shall be July 1st through June 30th.

The Board shall provide a Health Reimbursement Account (HRA) on the same terms as the Health Savings Account (HSA) for those Nurses not legally eligible for a HSA, with an unlimited roll on the HRA balance, not to exceed the total value of the HDHP deductible for that class of insurance.

The Board will provide the Flexible Dental Program to Nurses and eligible dependents, subject to the premium co-pays set forth below.

Eligible Employees will pay the following percentages of premium during this Agreement:

July 1, 2022 to June 30, 2023	10.5%
July 1, 2023 to June 30, 2024	11.0%
July 1, 2024 to June 30, 2025	12.0%
July 1, 2025 to June 30, 2026	13.0%

Section 125 Plan - Employee payments for premium costs shall be made through a payroll deduction, which will be done by the adoption of an Internal Revenue Code Section 125 pre- tax premium conversion account so that health insurance contributions may be made from pre-tax dollars.

Employees who waive health insurance coverage for the plan year, and do not receive alternate health insurance coverage through a family member who is employed by the District, shall be entitled to the followed annual payout:
Single - $2,500
Family/Employee plus one - $3,500

Section 3: Clothing and Shoe Allowance
The Board will provide an allowance of $375 per school year (to be paid in a separate check upon submission of receipt) to each Nurse for uniforms, shoes and other employment related expenses.

Section 4: Professional Development
Each Nurse employed by the Board shall be reimbursed one hundred percent (100%) for maintaining membership in the National Association of School Nurses (NASN).

ARTICLE 10
DISCIPLINE

No Nurse will be disciplined without just cause and shall generally be progressive commensurate with the infraction.

ARTICLE 11
RETIREMENT

Eligible Nurses shall participate in Plan B of the Municipal Employee Retirement Fund (MERF).

ARTICLE 12
GENERAL PROVISIONS

Section 1:
It is understood that this Agreement is subject to, and shall operate within, the framework of the Statutes of the State of Connecticut.

Section 2: Copies of Agreement
The Board shall provide nurses access to an electronic copy of this Agreement.

Section 3: Personnel Records
The official personnel records of nurses shall be kept on file by the Central Office. Nurses may schedule an appointment with Central Office to review their own file no more than twice per year. Nurses may also request up to one (1) free copy of relevant documents. Requests for copies must identify specific documents to be copied.

Section 4: Transportation
Any Nurse who, as a condition of employment, is required to travel from his/her primary worksite to other locations within the Town, and in the course of doing so is required to use his/her motor vehicle, shall be compensated at the IRS allowed mileage rate.

ARTICLE 13
GRIEVANCE PROCEDURE

A grievance is hereby defined to be any dispute concerning the interpretation or application of any provision of this Agreement. All grievances must advise the Board of the specific provisions claimed to have been violated, of the nature of the grievance, and the remedy requested. The following steps are agreed to for formally settling properly established grievances. The time limits set forth may be extended only by mutual written agreement.

Level One- Building Principal - Nurses who have grievances are encouraged to attempt to work the matter out informally with their immediate supervisor and/or principal, with an UPSEU

Representative present, if desired by the Nurse(s). In the event the issue is not resolved, a written grievance shall be submitted within ten (10) business days of the date he/she first became aware of the issue. A written decision will be rendered within ten (10) business days.

Level Two - Superintendent - In the event that, such Nurse is not satisfied with the disposition of his/her grievance at Level One, or in the event that no decision has been rendered within five (5) business days after presentation of the written grievance at Level One, he/she may appeal the written grievance to the Superintendent within fifteen (15) business days after the decision at Level One, or fifteen (15) business days after the grievance was presented in writing at Level One, whichever is sooner.

The Superintendent shall represent the administration at this level of the grievance procedure. Within the five (5) business days after the receipt of the written grievance by the Superintendent, the Superintendent or his/her designee shall meet with the aggrieved Nurse and an UPSEU Representative, in an effort to resolve the grievance. A written decision will be rendered within ten (10) business days following such meeting.

Level Three- In the event that the Union is not satisfied with the disposition of the grievance at Level Two, or in the event no decision has been rendered within fifteen (15) business days of the Level Two meeting with the Superintendent, the Union may within fifteen (15) business days after a decision by the Superintendent or fifteen (15) business days after the Level Two meeting with the Superintendent, whichever is sooner, present a request in writing to the State Board of Mediation and Arbitration for arbitration. Either the Union or the Board can request the mediation services of the SBMA after the Union files an arbitration claim.

The total cost of the grievance arbitration shall be borne equally by the UPSEU and the Board.

The authority of the arbitrator(s) shall be limited to the terms and provisions of this Agreement and the question or questions submitted. The arbitrator(s) shall be bound by this Agreement and shall not have the power to add to, delete from, or modify in any way any of the provisions of this Agreement. The decision of the arbitrator(s) shall be final and binding on the parties in accordance with law.

ARTICLE 14
PROBATIONARY PERIOD

Except as otherwise specifically provided in this Agreement, the first sixty (60) workdays of employment of a Nurse shall constitute such Nurse's probationary period during which no layoff, suspension, discipline or discharge shall be construed as a violation of any of the provisions of this Agreement or cause for or subject to the grievance and arbitration procedure provided herein. In the event that a Nurse is absent from work during his/her probationary period, or for those days for which work is not scheduled, the Nurse's probationary period shall be extended for each day the Nurse was absent from work.

ARTICLE 15
NO STRIKE/NO LOCKOUT

UPSEU agrees it will not authorize, instigate, sanction or condone any strike, work stoppage, concerted refusal to render services or interference with the orderly operation of the Board at any time. Any Nurse who engages in such activity shall be subject to disciplinary action, up to and including discharge. The Board agrees that it shall not lockout its employees at any time.

ARTICLE 16
UNION MEETING ON SCHOOL PROPERTY

Upon approval of the Superintendent or his/her designee, after a request at least twenty-four (24) hours in advance, UPSEU may call meetings in each school before or after school or during the lunch period whenever necessary, provided such meetings do not conflict with other scheduled activities.

ARTICLE 17
SAVINGS CLAUSE

No agreement, alteration, understanding, variation, waiver or modification of any of the terms, conditions, or covenants contained herein shall be made by the Board, and in no case shall it be binding upon the Parties hereto, unless such agreement is made and executed in writing between the Parties hereto and the same has been ratified by the Union.

The waiver of any breach or condition of this Agreement by either Party shall not constitute a precedent in the future enforcement of all the terms and conditions herein.

In the event that any federal or State legislation, governmental regulations or court decisions cause invalidation of any Article or Section of the Agreement, all other Articles and Sections not so invalidated shall remain in full force and effect

ARTICLE 18
DURATION

The Agreement shall be binding upon the Board and the UPSEU for the period of four (4) years from the 1st day of July, 2022 to and including the 30th day of June, 2026, unless otherwise expressly stated to the contrary herein.

IN WITNESS WHEREOF, the parties hereto have set forth their hands on the date(s) indicated below.

FOR THE SEYMOUR BOARD
OF EDUCATION

By _____

Title Board of Education Chairman

Date: 10-8-2022

FOR THE SCHOOL NURSES' UNION
UPSEU LOCAL 424, UNIT 93

By _____

Title RN- District Head Nurse

Date: 11-8-2022

By _____
Title KEVIN E BOYLE/UPSEU President
Date: 12-14-2022

APPENDIX A
WAGE SCHEDULE

	2022-23	2023-24	2024-25	2025-26
GWI	**2.25%**	**2.25%**	**2.25%**	**2.25%**
Hourly Rate	$42.81	$43.77	$44.77	$45.78
Annual (approx.)	$56,338	$57,601	$58,917	$60,246
Annual (approx.) w/Holiday	$59,634	$60,972	$62,365	$63,772

Hourly rate increases for the 2022-23 school year, will be effective and retroactive to July 1, 2022.

STIPENDS

	2022-23	2023-24	2024-25	2025-26
Head Nurse	**$7,000**	$7,157.50	$7,318.54	$7,483.21
High School Nurse	**$2,000**	$2,045.00	$2,091.01	$2,138.06
8th Grade Trip	**$1,500**	$1,533.75	$1,568.26	$1,603.55

APPENDIX B

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services **Coverage Period: 07/01/2022 - 06/30/2023**
Anthem® BlueCross and BlueShield **Coverage for: Individual + Family | Plan Type: PPO + HSA**
Seymour Town and BOE: Anthem Century Preferred PPO HSA P5 CSV

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://ese.anthem.com/ese/jsp/fi. 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 (888) 224-4896 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. $2,000/person or $4,000/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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive Care for In-Network Providers, Children's eye exam for 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?	$5,000/person or $6,850/family for In-Network Providers. $5,000/person or $10,000/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, the overall family out-of-pocket limit must be 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, Century Preferred. See www.anthem.com or call (888) 224-4896 for a list of network providers.	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	No.	You can see the specialist you choose without a referral.

to see a 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: In-Network Provider (You will pay the least)	What You Will Pay: Non-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	20% coinsurance	Virtual visits (Telehealth) benefits available.
	Specialist visit	0% coinsurance	20% coinsurance	Virtual visits (Telehealth) benefits available.
	Preventive care/screening/ immunization	No charge	20% coinsurance	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)	0% coinsurance	20% coinsurance	Costs may vary by site of service.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	20% coinsurance	Costs may vary by site of service.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.anthem.com/pharmacyinformation/	Tier 1 - Typically Generic	$5/prescription (retail and home delivery)	20% coinsurance (retail) and Not covered (home delivery)	For more information, refer to "National Drug List" at http://www.anthem.com/pharmacyinformation/ *See Prescription Drug section
	Tier 2 - Typically Preferred Brand	$25/prescription (retail) and $50/prescription (home delivery)	20% coinsurance (retail) and Not covered (home delivery)	
	Tier 3 - Typically Non-Preferred Brand and Generic drugs	$40/prescription (retail) and $80/prescription (home delivery)	20% coinsurance (retail) and Not covered (home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	20% coinsurance	------none------
	Physician/surgeon fees	0% coinsurance	20% coinsurance	------none------
If you need immediate medical attention	Emergency room care	0% coinsurance	Covered as In-Network	------none------
	Emergency medical transportation	0% coinsurance	Covered as In-Network	------none------
	Urgent care	0% coinsurance	20% coinsurance	------none------
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	20% coinsurance	100 days/benefit period for Inpatient rehabilitation
	Physician/surgeon fees	0% coinsurance	20% coinsurance	------none------

• For more information about limitations and exceptions, see plan or policy document at https://www.anthem.com/ecrdpa/fi

Common Medical Event	Services You May Need	What You Will Pay: In-Network Provider (You will pay the least)	What You Will Pay: Out-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit 0% coinsurance Other Outpatient 0% coinsurance	Office Visit 20% coinsurance Other Outpatient 20% coinsurance	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient -------none-------
	Inpatient services	0% coinsurance	20% coinsurance	-------none-------
If you are pregnant	Office visits	No charge	20% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	20% coinsurance	-------none-------
	Rehabilitation services	0% coinsurance	20% coinsurance	Costs may vary by site of service. *See Therapy Services section.
	Habilitation services	0% coinsurance	20% coinsurance	
	Skilled nursing care	0% coinsurance	20% coinsurance	120 days/benefit period for skilled nursing services.
	Durable medical equipment	0% coinsurance	20% coinsurance	*See Durable Medical Equipment Section
	Hospice services	0% coinsurance	20% coinsurance	-------none-------
If your child needs dental or eye care	Children's eye exam	No charge	20% coinsurance	*See Vision Services section
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	-------none-------

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.)

- Cosmetic surgery
- Dental Check-up
- Routine foot care unless you have been diagnosed with diabetes
- Dental care (Adult)
- Glasses for a child
- Weight loss programs
- Dental care (Pediatric)
- Long-term care

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

- Acupuncture
- Hearing aids 1 item(s)/ear every 2 benefit periods
- Bariatric surgery
- Infertility treatment
- Routine eye care (Adult) 1 exam/benefit period
- Chiropractic care 100 visits/benefit period combined with all other therapies
- Most coverage provided outside the United States. See www.bcbsglobalcore.com

* For more information about limitations and exceptions, see plan or policy document at https://apc.anthem.com/apcdps/6.

- Private-duty nursing $15,000 maximum/benefit period in a Home Setting only

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, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov. 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

Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov

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? 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.

* For more information about limitations and exceptions, see plan or policy document at https://ecc.anthem.com/ecodpa/fi.

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 prenatal care and a hospital delivery)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow-up care)	
The plan's overall deductible	$2,000	The plan's overall deductible	$2,000	The plan's overall deductible	$2,000
Specialist coinsurance	0%	Specialist coinsurance	0%	Specialist coinsurance	0%
Hospital (facility) coinsurance	0%	Hospital (facility) coinsurance	0%	Hospital (facility) coinsurance	0%
Other coinsurance	0%	Other coinsurance	0%	Other coinsurance	0%
This EXAMPLE event includes services like:		**This EXAMPLE event includes services like:**		**This EXAMPLE event includes services like:**	
Specialist office visits *(prenatal care)*		Primary care physician office visits *(including disease education)*		Emergency room care *(including medical supplies)*	
Childbirth/Delivery Professional Services		Diagnostic tests *(blood work)*		Diagnostic test *(x-ray)*	
Childbirth/Delivery Facility Services		Prescription drugs		Durable medical equipment *(crutches)*	
Diagnostic tests *(ultrasounds and blood work)*		Durable medical equipment *(glucose meter)*		Rehabilitation services *(physical therapy)*	
Specialist visit *(anesthesia)*					
Total Example Cost	**$12,700**	**Total Example Cost**	**$5,600**	**Total Example Cost**	**$2,800**
In this example, Peg would pay:		**In this example, Joe would pay:**		**In this example, Mia would pay:**	
Cost Sharing		*Cost Sharing*		*Cost Sharing*	
Deductibles	$2,000	Deductibles	$2,000	Deductibles	$2,000
Copayments	$10	Copayments	$700	Copayments	$0
Coinsurance	$0	Coinsurance	$0	Coinsurance	$0
What isn't covered		*What isn't covered*		*What isn't covered*	
Limits or exclusions	$60	Limits or exclusions	$20	Limits or exclusions	$0
The total Peg would pay is	**$2,070**	**The total Joe would pay is**	**$2,720**	**The total Mia would pay is**	**$2,000**

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 (888) 224-4896

Amharic (አማርኛ): ስለዚህ ሰነድ ማጎረፍ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (888) 224-4896 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 (888) 224-4896.

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար սատարող օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (888) 224-4896:

Bassa (Bàsɔ̀ Wùdù): Ń dyí dyí-dìè-dɛ́ bɛ̌ bɛ́dɛ́ bá cɛ̂è-dɛ̀ nìà ks dyí ní, ɔ mɔ̀ nì dyí-bɛ̀dɛ̀ìn-dɛ̀ bɛ́ ǹ ké gbo-kpá-kpá kè bɔ̌ kpɔ̀ dɛ́ ǹ bídí-wùdùùn bɔ́ pídyí. Bɛ́ ǹ ké wudu-zìin-nyɔ̀ dɔ̀ gbo wùdù ks, dá (888) 224-4896.

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 (888) 224-4896 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အခမဲ့အကူအညီကို အခမဲ့ကြားဝင် ပေးရရှိပိုပါ သင့်ဘာသာစကားဖြင့် ဖုန်းခေါ်ဆိုရန် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် တကားပြောခိုင်ရန် ဝ (888) 224-4896 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(888) 224-4896。

Dinka (Dinka): Na nɔŋ thɛɛc ne ke de ɣa thorɛ, ke ɣin nɔŋ loŋ be ɣi kuony ku wɛ̈ɛ̈ aleu be gɛ̈ɛ̈ɛ̈ ɣic ɣin ne thoŋ du ke cin wɛ̈u taauc ke piny. Te kɔ̈r ɣin ba nam wene nan ɣe thok gerɣic, ke ɣin cal (888) 224-4896.

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 (888) 224-4896.

Farsi (فارسی): 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 ۸۸۸) 224-4896 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 (888) 224-4896.

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 (888) 224-4896.

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 (888) 224-4896.

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 (888) 224-4896.

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 (888) 224-4896.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न है, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें(888) 224-4896 ।

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 nyam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (888) 224-4896.

Igbo (Igbo): O bụrụ 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 (888) 224-4896.

Ilokano (Ilokano): No addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda kadagiam a makuna ti tulong ken impormasyon babaen ti lengguahem nga awan ti bayad na. Tapno makatungtong ti mayna nga tagipatauna, awagan ti (888) 224-4896.

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 (888) 224-4896.

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 (888) 224-4896

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 (888) 224-4896 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរណាមួយទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយឥតគិតថ្លៃអំពីភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីដណ្តើមយកជាមួយអ្នកបកប្រែ សូមហៅ (888) 224-4896

Kirundi (Kirundi): Ugize ikibazo co anco cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe sta gisiro. Kugira uvugishe umusemuzi, ahura (888) 224-4896.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (888) 224-4896 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄຳຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ ເພື່ອໂອ້ລົມກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ (888) 224-4896.

Navajo (Diné): Díí naaltsoos bíká'igíí bahgo bína'idilkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nízaad k'ehjí bee nil hodoonih t'áadoo bąąh íiníigóó. Ata' haine'igíí ła' bich'į' hadeesdzih nínízingo koj' hodiilnih (888) 224-4896.

Nepali (नेपाली): यदि यो कागजातबारे तपाईसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईसँग छ। दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (888) 224-4896

Oromo (Oromiffaa): Sanadi kanaa waaan waliqabaate gaffi kamiyuu yoo qabdan taatan, Gargaarsa argachuu fi odeeffannoo afaan keetiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (888) 224-4896 bilbilla.

Pennsylvania Dutch (Deitsch): Wann du Frooge iwwer selle Document hoscht, dn hoscht die Recht un Helfe un Infocmation zu griege in dei Sehprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff (888) 224-4896 an.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (888) 224-4896.

Portuguese (Português): Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (888) 224-4896.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਕਿਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ (888) 224-4896 ਤੇ ਫ਼ੋਨ ਕਰੋ।

Language Access Services:

Romanian (Română): Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiți sprijin și informații în limba dumneavoastră în mod gratuit. Pentru a vă adresa unui interpret, contactați telefonic (888) 224-4896.

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (888) 224-4896.

Samoan (Samoa): Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou 'aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totogi. Ina ia talanoa i se tagata faaliliu, vili (888) 224-4896.

Serbian (Srpski): Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite (888) 224-4896.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (888) 224-4896.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (888) 224-4896.

Thai (ไทย): หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร (888) 224-4896 เพื่อพูดคุยกับล่าม

Ukrainian (Українська): якщо у вас виникають запитання з приводу цього документа, ви маєте право безкоштовно отримати допомогу й інформацію вашою рідною мовою. Щоб отримати послуги перекладача, зателефонуйте за номером (888) 224-4896.

Urdu (اردو): اگر اس دستاویز کے بارے میں آپ کا کوئی سوال ہے، تو آپ کو مفت اور اپنی زبان میں مفت معلومات حاصل کرنے کا حق حاصل ہے۔ کسی مترجم سے بات کرنے کے لئے، (888) 224-4896 پر کال کریں۔

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (888) 224-4896.

Yiddish (אידיש): אויב איר האט שאלות וועגן דעם דאקומענט, האט איר ד' רעכט צו באקומען דעם אינפארמאציע אין אייער שפראך אהן קיין פרייז. צו רעדן צו אן איבערזעצער, רופט (888) 224-4896 .

Yoruba (Yorùbá): Ti o ba ni èyikéyìí ibéèrè nípa ìkọsilẹ yìí, o ni ẹtọ lati gba ìrànwọ ati ìsọfúnni ni ede re fọfẹẹ. Bá wa ọgbufọ kan sọrọ, pe (888) 224-4896.

Language Access Services:

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building, Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services **Coverage Period: 07/01/2023 - 06/30/2024**
Anthem® BlueCross and BlueShield **Coverage for: Individual + Family | Plan Type: PPO + HSA**
Seymour Town and BOE: Anthem Century Preferred PPO HSA P5 CSV

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://mco.anthem.com/anedge/fi. 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 (888) 224-4896 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2,250/person or $4,500/family for In-Network Providers. $2,250/person or $4,500/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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive Care for In-Network Providers. Children's eye exam for 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?	$5,000/person or $6,850/family for In-Network Providers. $5,000/person or $10,000/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, the overall family out-of-pocket limit must be 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, Century Preferred. See www.anthem.com or call (888) 224-4896 for a list of network providers.	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	No.	You can see the specialist you choose without a referral.

to see a 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: In-Network Provider (You will pay the least)	What You Will Pay: Non-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	20% coinsurance	Virtual visits (Telehealth) benefits available.
	Specialist visit	0% coinsurance	20% coinsurance	Virtual visits (Telehealth) benefits available.
	Preventive care/screening/ immunization	No charge	20% coinsurance	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)	0% coinsurance	20% coinsurance	Costs may vary by site of service.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	20% coinsurance	Costs may vary by site of service.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.anthem.com/pharmacyinformation/	Tier 1 - Typically Generic	$5/prescription (retail and home delivery)	20% coinsurance (retail) and Not covered (home delivery)	For more information, refer to "National Drug List" at http://www.anthem.com/pharmacyinformation/ *See Prescription Drug section
	Tier 2 - Typically Preferred Brand	$25/prescription (retail) and $50/prescription (home delivery)	20% coinsurance (retail) and Not covered (home delivery)	
	Tier 3 - Typically Non-Preferred Brand and Generic drugs	$40/prescription (retail) and $80/prescription (home delivery)	20% coinsurance (retail) and Not covered (home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	20% coinsurance	------none------
	Physician/surgeon fees	0% coinsurance	20% coinsurance	------none------
If you need immediate medical attention	Emergency room care	0% coinsurance	Covered as In-Network	------none------
	Emergency medical transportation	0% coinsurance	Covered as In-Network	------none------
	Urgent care	0% coinsurance	20% coinsurance	------none------
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	20% coinsurance	100 days/benefit period for Inpatient rehabilitation.
	Physician/surgeon fees	0% coinsurance	20% coinsurance	------none------

* For more information about limitations and exceptions, see plan or policy document at https://apps.anthem.com/coverage/fi

Common Medical Event	Services You May Need	What You Will Pay: In-Network Provider (You will pay the least)	What You Will Pay: Non-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit 0% coinsurance Other Outpatient 0% coinsurance	Office Visit 20% coinsurance Other Outpatient 20% coinsurance	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient -------none-------
	Inpatient services	0% coinsurance	20% coinsurance	-------none-------
If you are pregnant	Office visits	No charge	20% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	20% coinsurance	-------none-------
	Rehabilitation services	0% coinsurance	20% coinsurance	Costs may vary by site of service. *See Therapy Services section.
	Habilitation services	0% coinsurance	20% coinsurance	
	Skilled nursing care	0% coinsurance	20% coinsurance	120 days/benefit period for skilled nursing services.
	Durable medical equipment	0% coinsurance	20% coinsurance	*See Durable Medical Equipment Section
	Hospice services	0% coinsurance	20% coinsurance	-------none-------
If your child needs dental or eye care	Children's eye exam	No charge	20% coinsurance	*See Vision Services section
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	-------none-------

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.)

- Cosmetic surgery
- Dental Check-up
- Routine foot care unless you have been diagnosed with diabetes
- Dental care (Adult)
- Glasses for a child
- Weight loss programs
- Dental care (Pediatric)
- Long-term care

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

- Acupuncture
- Hearing aids 1 item(s)/ear every 2 benefit periods
- Bariatric surgery
- Infertility treatment
- Routine eye care (Adult) 1 exam/benefit period
- Chiropractic care 100 visits/benefit period combined with all other therapies
- Most coverage provided outside the United States. See www.bcbsglobalcore.com

* For more information about limitations and exceptions, see plan or policy document at https://ece.anthem.com/ecedps/f6

- Private-duty nursing $15,000 maximum/benefit period in a Home Setting only

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, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov. 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

Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov

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? 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.

• For more information about limitations and exceptions, see plan or policy document at https://oon.anthem.com/oonlpo/fi

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)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow-up care)	
The plan's overall deductible	$2,250	The plan's overall deductible	$2,250	The plan's overall deductible	$2,250
Specialist coinsurance	0%	Specialist coinsurance	0%	Specialist coinsurance	0%
Hospital (facility) coinsurance	0%	Hospital (facility) coinsurance	0%	Hospital (facility) coinsurance	0%
Other coinsurance	0%	Other coinsurance	0%	Other coinsurance	0%
This EXAMPLE event includes services like:		**This EXAMPLE event includes services like:**		**This EXAMPLE event includes services like:**	
Specialist office visits *(prenatal care)*		Primary care physician office visits *(including disease education)*		Emergency room care *(including medical supplies)*	
Childbirth/Delivery Professional Services		Diagnostic tests *(blood work)*		Diagnostic test *(x-ray)*	
Childbirth/Delivery Facility Services		Prescription drugs		Durable medical equipment *(crutches)*	
Diagnostic tests *(ultrasounds and blood work)*		Durable medical equipment *(glucose meter)*		Rehabilitation services *(physical therapy)*	
Specialist visit *(anesthesia)*					
Total Example Cost	$12,700	**Total Example Cost**	$5,600	**Total Example Cost**	$2,800
In this example, Peg would pay:		**In this example, Joe would pay:**		**In this example, Mia would pay:**	
Cost Sharing		*Cost Sharing*		*Cost Sharing*	
Deductibles	$2,250	Deductibles	$2,250	Deductibles	$2,250
Copayments	$10	Copayments	$600	Copayments	$0
Coinsurance	$0	Coinsurance	$0	Coinsurance	$0
What isn't covered		*What isn't covered*		*What isn't covered*	
Limits or exclusions	$60	Limits or exclusions	$20	Limits or exclusions	$0
The total Peg would pay is	$2,320	**The total Joe would pay is**	$2,870	**The total Mia would pay is**	$2,250

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 (888) 224-4896

Amharic (አማርኛ): ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (888) 224-4896 ይደውሉ።

Arabic (العربية): إذا كان لديك أي أسئلة حول هذه الوثيقة، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. اتصل على (888) 224-4896 للتحدث إلى مترجم.

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար աոաձեղ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (888) 224-4896:

Bassa (Bàsɔ̀ Wùdìì): Ń dyi dyí-diè-dɛ̀ bě bédé bá cée-dɛ̀ nìà ks dyí ní, ɔ mɔ̀ ni dyí-bèdɛ̀in-dɛ̀ bé ǹ ké gbo-kpá-kpá kè bɔ̌ kpɔ̀ dé ǹ bídí-wùdìnìn bó pídyi. Bɛ́ ǹ ké wudu-zlin-nyɔ̀ dò gbo wùdù ks, dá (888) 224-4896.

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 (888) 224-4896 -(ভ কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အဆုက်အလက်များနှင့် အကူအညီကို အခမဲ့ရယူခွင့် ပေးစရာမလိုပဲ သင်ဘာသာစကားပြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ၀ (888) 224-4896 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(888) 224-4896。

Dinka (Dinka): Na nɔŋ thiɛɛc ne ke de ɣa thore, ke yin nɔŋ loŋ be yi kuony ku wɛ̈ɛ̈ aleu be gɛ̈ɛ̈ yic yin ne thoŋ du ke cin wɛ̈u taauc ke puny. Te kɔ̈ɛ̈ yin ba yam wene nin ye thok gerric, ke cin cal (888) 224-4896.

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 (888) 224-4896.

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 ۰ 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 (888) 224-4896.

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 (888) 224-4896.

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 (888) 224-4896.

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 (888) 224-4896.

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 (888) 224-4896.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे मे कोई प्रश्न है, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें(888) 224-4896 ।

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 nyam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (888) 224-4896.

Igbo (Igbo): Ọ bụrụ 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 (888) 224-4896.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong kan impormasyon babaen ti lengguahem nga awan ti bayad na. Tapno makatungtong ti mayna nga tagipatarus, awagan ti (888) 224-4896.

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 (888) 224-4896.

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 (888) 224-4896

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 (888) 224-4896 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរជុំវិញឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយឥតគិតថ្លៃជាភាសារបស់អ្នក។ សូមទូរស័ព្ទ (888) 224-4896 ដើម្បីនិយាយជាមួយអ្នកបកប្រែ

Kirundi (Kirundi): Ugize ikibazo co anco cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe sta gisiro. Kugira uvugishe umusemuzi, ahura (888) 224-4896.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (888) 224-4896 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄຳຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ ເພື່ອໂອ້ລົມກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ (888) 224-4896.

Navajo (Diné): Díí naaltsoos bíká'igíí bahgo bina'idilkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nil hodoonih t'ázdoo bąąh íiníigóó. Atą' haine'igíí ba' bich'į' hadeesdzih nínízingo kojí' hodíilnih (888) 224-4896.

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 (888) 224-4896

Oromo (Oromiffa): Sanadi kana waliin walqabate gaffi kamiyyuu yoo qabdan tanaan, Gargaarsa ogeeyyii fi odeeffannoo afaan keetiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (888) 224-4896 bilbilla.

Pennsylvania Dutch (Deitsch): Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Helfe un Infoemation zu griege in dei Schprooch mitous Koscht. Um mit en Iwwersetze zu schwetze, ruff (888) 224-4896 aa.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (888) 224-4896.

Portuguese (Português): Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (888) 224-4896.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ (888) 224-4896 ਤੇ ਕਾਲ ਕਰੋ।

Language Access Services:

Romanian (Română): Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiți sprijin în limba dumneavoastră în mod gratuit. Pentru a vă adresa unui interpret, contactați telefonic (888) 224-4896.

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (888) 224-4896.

Samoan (Samoa): Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou 'aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totogi. Ina ia talanoa i se tagata faaliliu, vili (888) 224-4896.

Serbian (Srpski): Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite (888) 224-4896.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (888) 224-4896.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (888) 224-4896.

Thai (ไทย): หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร (888) 224-4896 เพื่อพูดคุยกับล่าม

Ukrainian (Українська): якщо у вас виникають запитання з приводу цього документа, ви маєте право безкоштовно отримати допомогу й інформацію вашою рідною мовою. Щоб отримати послуги перекладача, зателефонуйте за номером (888) 224-4896.

Urdu (اردو): اگر اس دستاویز کے بارے میں آپ کا کوئی سوال ہے، تو آپ کو مفت اور اپنی زبان میں مفت معلومات حاصل کرنے کا حق حاصل ہے۔ کسی مترجم سے بات کرنے کے لئے، (888) 224-4896 پر کال کریں۔

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (888) 224-4896.

Yiddish (ייִדיש): אויב איר האט שאלות וועגן דעם דאקומענט, האט איר די רעכט צו באקומען דעם אינפארמאציע אין אייער שפראך אהן קיין פריז. צו רעדן צו אן איבערזעצער, רופט (888) 224-4896 .

Yoruba (Yorùbá): Ti o bá ní èyikéyìí ibéèrè nípa ìkọsílẹ̀ yìí, o ní ẹ̀tọ́ látí gbà ìrànwọ́ àti ìwífún ní èdè rẹ lọ́fẹ̀ẹ́. Bá wa ọ̀gbufọ̀ kan sọ̀rọ̀, pe (888) 224-4896.

Language Access Services:

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

APPENDIXC
Summary of Flex Dental Benefits Flexible Dental Plan

Summary of Benefits

Anthem Dental Essential Choice PPO

Seymour Town & Boe- Boe Plan

Anthem Blue Cross and Blue Shield Dental Connecticut Network

Anthem

WELCOME TO YOUR DENTAL PLAN!

Regular dental checkups can help find early warning signs of certain health problems, which means you can get the care you need to get healthy. So, don't skimp on your dental care, good oral care can mean better overall health!

Powerful and easily accessible member tools.

- **Ask a Hygienist:** Dental members can simply email their dental questions to a team of licensed dental professionals who in turn will respond in about 24 hours.
- **Dental Health Risk Assessment:** We want our dental members to better understand their oral health and their risk factors for tooth decay, gum disease and oral cancer. This easy to use online tool can help them do this.
- **Dental Care Cost Estimator:** In order to help our dental member better understand the cost of their dental care, we offer access to a user-friendly, web-based tool that provides estimates on common dental procedures and treatments when using a network dentist.
- **Mobile Capabilities:** With our latest mobile application, members can find a network dentist as well as view their claims. Our application is available for both Android and Apple phones.

Dentists in your plan network.

- You'll save money when you visit a dentist in your plan network because Anthem and the dentist have agreed on pricing for covered services. Dentists who are not in your plan network have not agreed to pricing, and may bill you for the difference between what Anthem pays them and what the dentist usually charges.
- To find a dentist by name or location, go to anthem.com or call dental customer service at the number listed on the back of your ID card.

Ready to use your dental benefits?

- Choose a dentist from the network
- Make an appointment
- Show the office staff your member ID card
- Pay any deductible or copay that is part of your plan

Need to contact us?
See the back of your ID card for how to call, write or email us.

Your dental benefits at a glance

The following benefit summary outlines how your dental plan works and provides you with a quick reference of your dental plan benefits. For complete coverage details, please refer to your policy.

	In-Network	Out-of-Network
Coverage Year	Contract Year	
Annual Benefit Maximum		
• Per insured person		
• Diagnostic & Preventive Services are applied to the Annual Benefit Maximum	$1,500	$1,500
Annual Maximum Carryover	No	No
Orthodontic Lifetime Benefit Maximum		
• Per eligible child	$1,000	$1,000
Annual Deductible		
• Per insured person	$50	$50
• Family maximum	3x single member deductible	3x single member deductible
Deductible Waived for Diagnostic/Preventive Services	Yes	Yes
Out-of-Network Reimbursement	80th percentile	

Dental Services	In-Network Anthem Pays	Out-of-Network Anthem Pays	Waiting Period
Diagnostic & Preventive Services • Periodic oral exam o Limited to two per 12 months • Teeth cleaning (prophylaxis) o Limited to two per 12 months; combined with periodontal maintenance • Bitewing X-rays o Limited to two sets per 12 months • Full-Mouth or Panoramic X-rays o Limited to one per 36 months • Fluoride application o Limited to two per 12 months through age 18 • Sealant application o Limited to one per 60 months through age 18	100% coinsurance	100% coinsurance	No waiting period
Basic (Restorative) Services • Consultation (second opinion); only with X-rays and no other services o Limited to one per 12 months • Space maintainer insertion covered at Diagnostic/Preventive level o Limited to one per tooth space per lifetime through age 18 • Amalgam (silver-colored) filling o Limited to one per tooth surface per 24 months • Composite (tooth-colored) filling o Limited to one per tooth surface per 24 months posterior (back) fillings not paid as an amalgam (silver-colored filling) • Brush biopsy (cancer test) o Limited to one per 12 months, all ages	80% coinsurance	80% coinsurance	No waiting period
Endodontics (Non-Surgical) • Root Canal (permanent teeth only) o Limited to one per tooth per lifetime	80% coinsurance	80% coinsurance	No waiting period
Endodontics (Surgical) • Apicoectomy and apexification o Limited to one per tooth per lifetime; permanent teeth only	80% coinsurance	80% coinsurance	No waiting period
Periodontics (Non-Surgical) • Periodontal maintenance o Limited to four per 12 months, combined with teeth cleanings • Scaling and root planning, when the tooth pocket has a depth of four millimeters or greater o Limited to one per quadrant per 24 months	80% coinsurance	80% coinsurance	No waiting period
Periodontics (Surgical) • Periodontal surgery (osseous, gingivectomy, graft procedures) o Limited to one per quadrant per 36 months	80% coinsurance	80% coinsurance	No waiting period
Oral Surgery (Simple) • Simple extraction o Limited to one per tooth per lifetime	80% coinsurance	80% coinsurance	No waiting period
Oral Surgery (Complex) • Surgical extraction o Limited to one per tooth per lifetime	80% coinsurance	80% coinsurance	No waiting period
Major (Restorative) Services • Crowns, onlays, veneers o Limited to one per tooth per 60 months	50% coinsurance	50% coinsurance	No waiting period
Prosthodontics • Dentures and bridges o Limited to one per tootharch per 60 months • Implant placement o Not covered • Implant prosthodontics o Not covered	50% coinsurance	50% coinsurance	No waiting period
Repairs/Adjustments • Crown, denture, and bridge repairs o Limited to one per tooth per 12 months; not within 6 months of placement • Denture and bridge adjustments o Limited to two per tooth per 12 months; not within 6 months of placement	80% coinsurance	80% coinsurance	No waiting period

Dental Services (continued)	In-Network Anthem Pays	Out-of-Network Anthem Pays	Waiting Period
Child Orthodontic Services • Through age 19	50% coinsurance	50% coinsurance	No waiting period
Temporomandibular Joint Disorder (TMJ) • X-rays, splints, and surgical procedures including arthroscopy and orthotic devices • Not covered	Not covered	Not covered	Not covered
Cosmetic Tooth Whitening • Not covered	Not covered	Not covered	Not covered

NOTE: Cosmetic benefits, such as tooth bleaching, in an insurance policy may have income tax implications for both employer groups and plan members. For example, the dollar value of the cosmetic benefit may be considered part of an individual's taxable income. For more information concerning the tax ramifications of cosmetic insurance benefits, please contact a legal or tax advisor.

Additional Services and Programs	
Anthem Whole Health Connection - Dental℠ • For members with certain health conditions, additional dental benefits are available without a deductible or waiting periods. Eligible services are paid at 100% and won't reduce your coverage year annual maximum (if applicable)	Included
Accidental Dental Injury Benefit • Provides members 100% coverage for accidental injuries to teeth up to the coverage year annual maximum (if applicable). No deductibles, member coinsurance, or waiting periods apply	Included
Extension of Benefits • Following termination of coverage, members are provided up to 60 days to complete treatment started prior to their termination of coverage under the plan and eligible services will be covered	Included
International Emergency Dental Program • Provides emergency dental benefits while working or traveling abroad from licensed, English-speaking dentists. Eligible covered services will be paid 100% with no deductibles, member coinsurance, or waiting periods and won't reduce the member coverage year annual maximum (if applicable)	Included

Additional Limitations & Exclusions

Below is a partial listing of non-covered services under your dental plan. Please see your policy for a full list.

Services provided before or after the term of this coverage - Services received before your effective date or after your coverage ends, unless otherwise specified in the dental plan certificate

Orthodontics (unless included as part of your dental plan benefits) including orthodontic braces, appliances and all related services

Cosmetic dentistry (unless included as part of you dental plan benefits) provided by dentists solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (cavities) exist

Drugs and medications including intravenous conscious sedation, IV sedation and general anesthesia when performed with nonsurgical dental care

Analgesia, analgesic agents, and anxiolysis nitrous oxide, therapeutic drug injections, medicines or drugs for nonsurgical or surgical dental care except that intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

Waiting periods for endodontic, periodontic and oral surgery services may differ from other Basic Services or Major Services under the same dental plan. There is a 24 month waiting period for replacement of congenitally missing teeth or teeth extracted prior to coverage under this plan.

This is not a contract; it is a partial listing of benefits and services. All covered services are subject to the conditions, limitations, exclusions, terms and provisions of your policy. In the event of a discrepancy between the information in this summary and the policy, your policy will prevail.