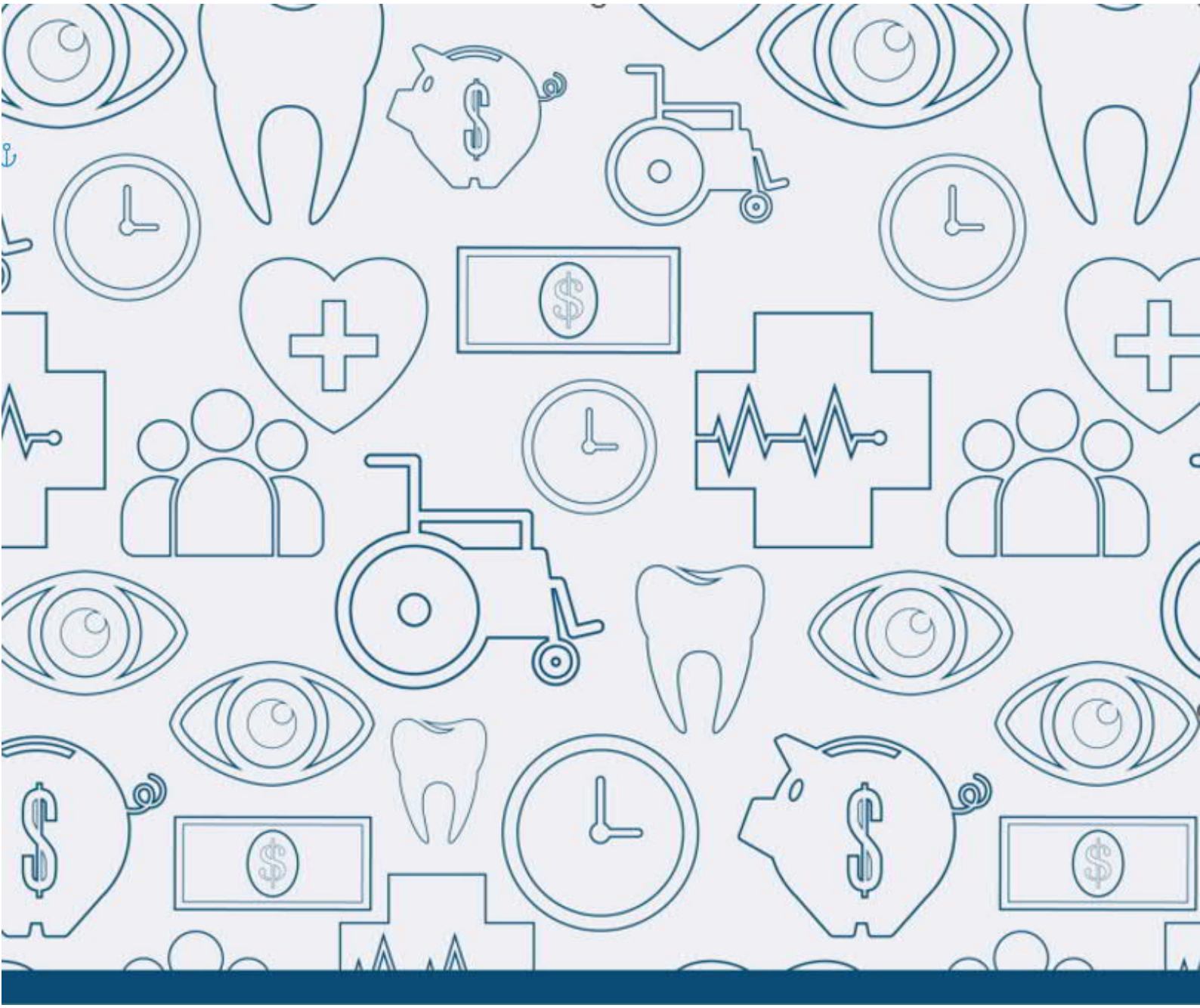


# Norwalk Inn & Conference Center

The Norwalk Inn & Conference Center
The rest is history.™

## Employee Benefits Open Enrollment Guide

Plan Year: November 1, 2023- October 31, 2024

# CHOOSE THE BEST BENEFITS FOR YOU AND YOUR FAMILY.

Welcome to Open Enrollment for 2023! Norwalk Inn & Conference Center is excited to announce our new, comprehensive benefits package offered to all full-time eligible employees beginning this November!

We strive to provide you and your family with a comprehensive and valuable benefits package. We want to make sure you're getting the most out of our benefits—that's why we've put together this Open Enrollment guide. Open enrollment is a short period each year when you can make changes to your benefits. This guide will outline the benefits that Norwalk Inn offers, so you can identify which offerings are best for you and your family.

Elections that you make during open enrollment will become effective on November, 1, 2023. If you do not enroll during open enrollment, you will not be eligible to enroll or make changes again until the next annual open enrollment period, unless you experience a qualifying life event, which are outlined on page 2.

If you have questions about any of the benefits mentioned in this guide, please don't hesitate to reach out to our licensed agent, Chelsea Baden at ADP, Chelsea.Baden@adp.com.

## WHO IS ELIGIBLE?

If you're a full-time employee at Norwalk Inn & Conference Center, you're eligible to enroll in the benefits outlined in this guide. Fulltime employees are those who work 30 or more hours per week. In addition, the following family members are eligible for medical and dental coverage:

- Spouse
- Dependent Child up to age 26

## HOW TO ENROLL

Open enrollment will be administered through the ADP Ease Benefits platform. You will be emailed a "Welcome to Ease" which will navigate you to our custom enrollment site. Through the platform, you will be able to review plan details as well as per payroll pricing for each line of coverage to make your elections electronically.

## WHEN TO ENROLL

Open enrollment will run in the month of October. Specific dates will be communicated to you once our ADP platform is ready for Open Enrollment. Periodic email reminders will be sent throughout the process. Please do not delay in logging in to review and elect your benefits! The benefits you choose during open enrollment will become effective on November 1, 2023.

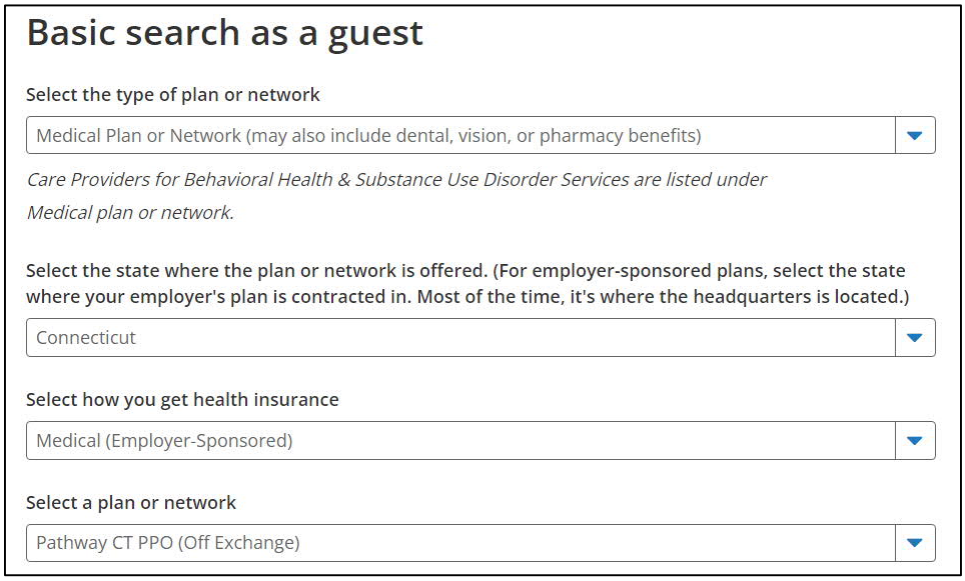
## WHEN TO MAKE CHANGES

You can make changes during open enrollment. Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next open enrollment period. Qualifying events include the following:

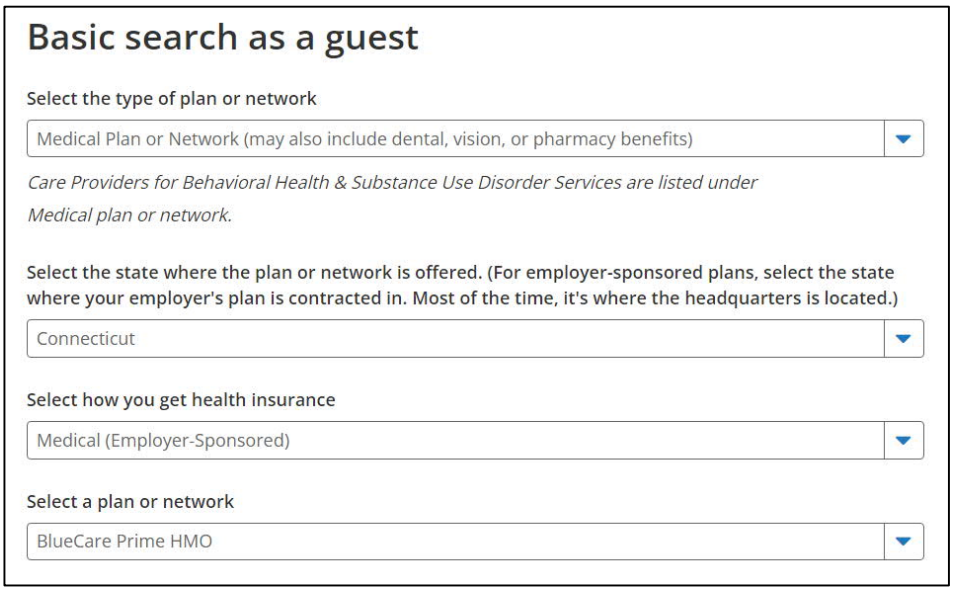
- Marriage, divorce, or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child, or other qualified dependent
- Change in residence
- Change in employment status or a change in coverage under another employer-sponsored plan

# MEDICAL PLANS BEING OFFERED

- ## Anthem Gold Pathway CT PPO 2000/20%/5000 Value
  - To search providers in network:
    - Visit http://www.anthem.com/find-care/
    - Select State
    - Click “Find Care” then click “Basic Search as Guest”




- ## Anthem Silver BlueCare Prime HMO 5000/25%/9000
  - To search providers in network:
    - Visit http://www.anthem.com/find-care/
    - Select State
    - Click “Basic Search as Guest”
    - Enter the Following Criteria into the Search Tool:



# Anthem Gold Pathway CT PPO 2000/20%/5000 Value

## Age-banded Pricing

*Your employer pays 50% of your monthly, single employee premium.

| Age | Rate | Age | Rate | Age | Rate |
|---|---|---|---|---|---|
| 0-14 | $377.15 | 31 | $571.40 | 48 | $806.07 |
| 15 | $410.68 | 32 | $583.23 | 49 | $841.08 |
| 16 | $423.50 | 33 | $590.63 | 50 | $880.52 |
| 17 | $436.31 | 34 | $598.51 | 51 | $919.46 |
| 18 | $450.12 | 35 | $602.46 | 52 | $962.36 |
| 19 | $463.92 | 36 | $606.40 | 53 | $1,005.74 |
| 20 | $478.22 | 37 | $610.35 | 54 | $1,052.58 |
| 21 | $493.01 | 38 | $614.29 | 55 | $1,099.41 |
| 22 | $493.01 | 39 | $622.18 | 56 | $1,150.19 |
| 23 | $493.01 | 40 | $630.07 | 57 | $1,201.47 |
| 24 | $493.01 | 41 | $641.90 | 58 | $1,256.19 |
| 25 | $494.98 | 42 | $653.24 | 59 | $1,283.31 |
| 26 | $504.84 | 43 | $669.01 | 60 | $1,338.03 |
| 27 | $516.67 | 44 | $688.73 | 61 | $1,385.36 |
| 28 | $535.90 | 45 | $711.91 | 62 | $1,416.42 |
| 29 | $551.68 | 46 | $739.52 | 63 | $1,455.37 |
| 30 | $559.57 | 47 | $770.57 | 64+ | $1,479.03 |

# Anthem Silver BlueCare Prime HMO 5000/25%/9000

## Age-banded Pricing

*Your employer pays 50% of your monthly, single employee premium.

| Age | Rate | Age | Rate | Age | Rate |
|---|---|---|---|---|---|
| 0-14 | $446.62 | 31 | $676.65 | 48 | $954.55 |
| 15 | $486.32 | 32 | $690.66 | 49 | $996.00 |
| 16 | $501.50 | 33 | $699.42 | 50 | $1,042.70 |
| 17 | $516.68 | 34 | $708.76 | 51 | $1,088.82 |
| 18 | $533.03 | 35 | $713.43 | 52 | $1,139.62 |
| 19 | $549.37 | 36 | $718.10 | 53 | $1,190.99 |
| 20 | $566.31 | 37 | $722.77 | 54 | $1,246.46 |
| 21 | $583.82 | 38 | $727.44 | 55 | $1,301.92 |
| 22 | $583.82 | 39 | $736.78 | 56 | $1,362.05 |
| 23 | $583.82 | 40 | $746.12 | 57 | $1,422.77 |
| 24 | $583.82 | 41 | $760.13 | 58 | $1,487.57 |
| 25 | $586.16 | 42 | $773.56 | 59 | $1,519.68 |
| 26 | $597.83 | 43 | $792.24 | 60 | $1,584.49 |
| 27 | $611.84 | 44 | $815.60 | 61 | $1,640.53 |
| 28 | $634.61 | 45 | $843.04 | 62 | $1,677.31 |
| 29 | $653.29 | 46 | $875.73 | 63 | $1,723.44 |
| 30 | $662.64 | 47 | $912.51 | 64+ | $1,751.46 |

**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/75E9SMG01012023 . 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) 837-8539 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. $6,000/person or $12,000/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. Primary Care. Preventive Care. Certain Prescription Drugs. Vision. 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?** | $5,000/person or $10,000/family for In-Network Providers. $15,000/person or $30,000/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, Pathway CT PPO. See www.anthem.com or call (855) 837-8539 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. |

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 | $25/visit deductible does not apply | 50% coinsurance | Virtual visits (Telehealth) benefits available. |
| | Specialist visit | $60/visit | 50% coinsurance | Virtual visits (Telehealth) benefits available. |
| | Preventive care/screening/ immunization | No charge | 50% 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) | $25/visit deductible does not apply | 50% coinsurance | --------none-------- |
| | Imaging (CT/PET scans, MRIs) | 20% 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/ | Tier 1a - Typically Lower Cost Generic | No charge (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 |
| | Tier 1b - Typically Generic | $10/prescription, deductible does not apply (retail) and $25/prescription, deductible does not apply (home delivery) | 50% coinsurance (retail and home delivery) | |
| | Tier 2 - Typically Preferred Brand | $60/prescription, deductible does not apply (retail) and $180/prescription, deductible does not apply (home delivery) | 50% coinsurance (retail and home delivery) | |
| | Tier 3 - Typically Non-Preferred Brand and Generic drugs | 30% coinsurance up to $500/prescription (retail) and 30% coinsurance up to $1,500/prescription (home delivery) | 50% coinsurance (retail and home delivery) | |
| | Tier 4 - Typically Preferred Specialty (brand and generic) | 30% coinsurance up to $1,000/prescription (retail and home delivery) | 50% coinsurance (retail and home delivery) | |

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/75E9SMG01012023.

| 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 have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 50% coinsurance | --------none-------- |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | --------none-------- |
| **If you need immediate medical attention** | Emergency room care | 20% coinsurance | Covered as In-Network | --------none-------- |
| | Emergency medical transportation | 20% coinsurance | Covered as In-Network | Non-emergency non-network Ambulance Services are limited to $50,000 per trip. |
| | Urgent care | $100/visit | 50% coinsurance | --------none-------- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 50% coinsurance | 90 days/benefit period for Inpatient rehabilitation and skilled nursing services combined. |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | --------none-------- |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office Visit<br>$25/visit deductible does not apply<br>Other Outpatient<br>20% coinsurance | Office Visit<br>50% coinsurance<br>Other Outpatient<br>50% coinsurance | Office Visit<br>Virtual visits (Telehealth) benefits available.<br>Other Outpatient<br>--------none-------- |
| | Inpatient services | 20% coinsurance | 50% coinsurance | --------none-------- |
| **If you are pregnant** | 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). |
| | Childbirth/delivery professional services | 0% coinsurance | 50% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 50% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 25% coinsurance, Home Health Care deductible applies | 25% coinsurance, Home Health Care deductible applies | 100 visits/benefit period. |
| | Rehabilitation services | $30/visit | 50% coinsurance | *See Therapy Services section. |
| | Habilitation services | $30/visit | 50% coinsurance | |
| | Skilled nursing care | 20% coinsurance | 50% coinsurance | 90 days/benefit period for Inpatient rehabilitation and skilled nursing services combined. |
| | Durable medical equipment | 50% coinsurance | 50% coinsurance | *See Durable Medical Equipment Section |
| | Hospice services | 20% coinsurance | 50% coinsurance | --------none-------- |

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/75E9SMG01012023.

| 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 your child needs dental or eye care** | Children's eye exam | $30/visit, deductible does not apply | 50% coinsurance, deductible does not apply | *See Vision Services section |
| | Children's glasses | No charge | 50% coinsurance, deductible does not apply | |
| | Children's dental check-up | No charge | No charge | *See Dental Services section |

**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.)**

- Bariatric surgery
- Long-term care
- Weight loss programs
- Cosmetic surgery
- Private-duty nursing
- Dental care (Adult)
- 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/benefit period
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Hearing aids 1 item(s) every 2 years
- Routine eye care (Adult) 1 exam/benefit period

**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 Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform, 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

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform

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

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/75E9SMG01012023.

**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://eoc.anthem.com/eocdps/75E9SMG01012023.

## 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 | $2,000 |
| Specialist *copayment* | $60 |
| Hospital (facility) *coinsurance* | 20% |
| Other *copayment* | $25 |

**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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,000 |
| Copayments | $400 |
| Coinsurance | $1,700 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$4,160** |

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

| | |
|---|---|
| The plan's overall deductible | $2,000 |
| Specialist *copayment* | $60 |
| Hospital (facility) *coinsurance* | 20% |
| Other *copayment* | $25 |

**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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $300 |
| Copayments | $1,800 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$2,120** |

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

| | |
|---|---|
| The plan's overall deductible | $2,000 |
| Specialist *copayment* | $60 |
| Hospital (facility) *coinsurance* | 20% |
| Other *copayment* | $25 |

**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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,000 |
| Copayments | $400 |
| Coinsurance | $10 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,410** |

The plan would be responsible for the other costs of these EXAMPLE covered services.

**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/75ESSMG01012023 . 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) 837-8539 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $5,000/person or $10,000/family for In-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. Primary Care. Specialist Visit. Preventive Care. Certain Prescription Drugs. Vision. 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 In-Network Providers. 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. | 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, BlueCare Prime. See www.anthem.com or call (855) 837-8539 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?** | Yes. | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist. |

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | 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 | $50/visit deductible does not apply | Not covered | Virtual visits (Telehealth) benefits available. |
| | Specialist visit | $100/visit deductible does not apply | Not covered | Virtual visits (Telehealth) benefits available. |
| | Preventive care/screening/ immunization | No charge | Not covered | 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) | Lab – Office<br>$100/visit deductible does not apply<br>X-Ray – Office<br>$50/visit deductible does not apply | Lab – Office<br>Not covered<br>X-Ray – Office<br>Not covered | --------none-------- |
| | Imaging (CT/PET scans, MRIs) | 25% coinsurance | Not covered | --------none-------- |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at http://www.anthem.com/pharmacyinformation/ | Tier 1a - Typically Lower Cost Generic | No charge (retail and home delivery) | Not covered (retail and home delivery) | For more information, refer to "Select Drug List" at http://www.anthem.com/pharmacyinformation/<br>*See Prescription Drug section |
| | Tier 1b - Typically Generic | $10/prescription, deductible does not apply (retail) and $25/prescription, deductible does not apply (home delivery) | Not covered (retail and home delivery) | |
| | Tier 2 - Typically Preferred Brand | $60/prescription, deductible does not apply (retail) and $180/prescription, deductible does not apply (home delivery) | Not covered (retail and home delivery) | |
| | Tier 3 - Typically Non-Preferred Brand and Generic drugs | 30% coinsurance up to $500/prescription, deductible does not apply (retail) and 30% coinsurance up to | Not covered (retail and home delivery) | |

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/75ESSMG01012023.

| 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) | |
| | | $1,500/prescription, deductible does not apply (home delivery) | | |
| | Tier 4 - Typically Preferred Specialty (brand and generic) | 30% coinsurance up to $1,000/prescription, deductible does not apply (retail and home delivery) | Not covered (retail and home delivery) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 25% coinsurance | Not covered | --------none-------- |
| | Physician/surgeon fees | 25% coinsurance | Not covered | --------none-------- |
| **If you need immediate medical attention** | Emergency room care | 25% coinsurance | Covered as In-Network | --------none-------- |
| | Emergency medical transportation | 25% coinsurance deductible does not apply | Covered as In-Network | Non-emergency non-network Ambulance Services are limited to $50,000 per trip. |
| | Urgent care | $100/visit deductible does not apply | Covered as In-Network | --------none-------- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 25% coinsurance | Not covered | 90 days/benefit period for Inpatient rehabilitation and skilled nursing services combined for In-Network Providers. |
| | Physician/surgeon fees | 25% coinsurance | Not covered | --------none-------- |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office Visit<br>$50/visit deductible does not apply<br>Other Outpatient<br>25% coinsurance | Office Visit<br>Not covered<br>Other Outpatient<br>Not covered | Office Visit<br>Virtual visits (Telehealth) benefits available.<br>Other Outpatient<br>--------none-------- |
| | Inpatient services | 25% coinsurance | Not covered | --------none-------- |
| **If you are pregnant** | Office visits | No charge | Not covered | 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 | Not covered | |
| | Childbirth/delivery facility services | 25% coinsurance | Not covered | |
| **If you need help recovering or** | Home health care | 25% coinsurance, Home Health Care deductible applies | Not covered | 100 visits/benefit period for In-Network Providers. |

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/75ESSMG01012023.

| 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) | |
| **have other special health needs** | Rehabilitation services | $30/visit deductible does not apply | Not covered | *See Therapy Services section. |
| | Habilitation services | $30/visit deductible does not apply | Not covered | |
| | Skilled nursing care | 25% coinsurance | Not covered | 90 days/benefit period for Inpatient rehabilitation and skilled nursing services combined for In-Network Providers. |
| | Durable medical equipment | 50% coinsurance | Not covered | *See Durable Medical Equipment Section |
| | Hospice services | 25% coinsurance | Not covered | --------none-------- |
| **If your child needs dental or eye care** | Children's eye exam | $30/visit, deductible does not apply | Not covered | *See Vision Services section |
| | Children's glasses | No charge | Not covered | |
| | Children's dental check-up | No charge | Not covered | *See Dental Services section |

## 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.)**

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

**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/benefit period
- Routine eye care (Adult) 1 exam/benefit period
- Hearing aids 1 item(s) every 2 years

**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 Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform, or contact Anthem at the number on the back of your

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/75ESSMG01012023.

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

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform

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://eoc.anthem.com/eocdps/75ESSMG01012023.

## 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 | $5,000 |
| Specialist *copayment* | $100 |
| Hospital (facility) *coinsurance* | 25% |
| Other *copayment* | $100 |

**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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $5,000 |
| Copayments | $700 |
| Coinsurance | $1,500 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$7,260** |

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

| | |
|---|---|
| The plan's overall deductible | $5,000 |
| Specialist *copayment* | $100 |
| Hospital (facility) *coinsurance* | 25% |
| Other *copayment* | $100 |

**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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $2,200 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$2,220** |

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

| | |
|---|---|
| The plan's overall deductible | $5,000 |
| Specialist *copayment* | $100 |
| Hospital (facility) *coinsurance* | 25% |
| Other *copayment* | $100 |

**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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,000 |
| Copayments | $500 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,700** |

The plan would be responsible for the other costs of these EXAMPLE covered services.

# Your Employee Advocacy Center (EAC) is Here for You.

## Education | Guidance | Support

## Do you find health benefits confusing?

- How do I replace a lost ID card?
- What's my deductible for out-of-network services?
- How do I appeal a claim?

## That's why the EAC is just a phone call away!

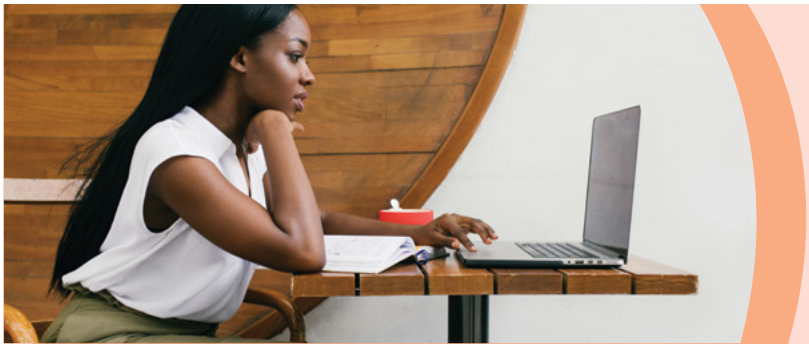
The Employer Advocacy Center from Automatic Data Processing Insurance Agency, Inc. (ADPIA®) is a dedicated service center staffed by a team of knowledgeable, fully-licensed agency consultants offering support, education and solutions for your quick benefit questions to complex or sensitive employee benefit issues.

## WHAT'S IN IT FOR YOU?

Accurate and up-to-date information regarding your health benefit plan(s)

A single, trusted source to answer your questions and help explain your coverage details

Licensed, HIPAA-compliant agents who maintain confidentiality and eliminate employer involvement in your personal health matters



## How can the EAC help you today?

**Employer Advocacy Center**

Phone: (866) 892-3383

Hours: M-F 8:30AM-8:00PM EST

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