



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.anthem.com/ca/sisc](http://www.anthem.com/ca/sisc) or by calling 1-800-825-5541.

| Important Questions                                       | Answers  | Why this Matters:   |
|---|--|---|
| What is the overall <u>deductible</u> ?                   | <b>\$0</b>   | See the chart starting on page 2 for your costs for services this plan covers.  |
| Are there other <u>deductibles</u> for specific services? | Yes. Brand drugs <b>\$200/\$500</b><br>Individual/Family   | You must pay all the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.  |
| Is there an <u>out-of-pocket limit</u> on my expenses?    | Yes. Annual copayment maximum:<br><b>\$1,500</b> per individual /<br><b>\$3,000</b> per family                                       | The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.  |
| What is not included in the <u>out-of-pocket limit</u> ?  | Premiums, balance billed charges, copayments for infertility services and health care this plan doesn't cover.                       | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .  |
| Is there an overall annual limit on what the plan pays?   | No.  | The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.  |
| Does this plan use a <u>network of providers</u> ?        | Yes. For a list of <u>providers</u> , see <a href="http://www.anthem.com/ca/sisc">www.anthem.com/ca/sisc</a> or call 1-800-825-5541. | If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> . |
| Do I need a referral to see a <u>specialist</u> ?         | Yes.   | This plan will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have the plan's permission before you see the <u>specialist</u> .   |
| Are there services this plan doesn't cover?               | Yes.   | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <u>excluded services</u> .   |



- Copayments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- Coinsurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if

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# Anthem Blue Cross: Premier 20/200; Rx 10-35/200

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 10/01/2012 – 09/30/2013

Coverage for: Individual/Family | Plan Type: HMO

the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.

- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event  | Services You May Need                            | Your Cost If You Use an In-network Provider             | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions  |
|---|--|---|---|---|
| <b>If you visit a health care provider's office or clinic</b> | Primary care visit to treat an injury or illness | \$20/visit  | Not Covered                                     | —————none—————  |
|   | Specialist visit                                 | \$20/visit  | Not Covered                                     | —————none—————  |
|   | Other practitioner office visit                  | <u>Acupuncture &amp; Chiropractor</u><br>\$20/visit     | Not Covered                                     | Combined limit of 60-days period of care for Physical, Speech, Occupational and Chiropractic therapy.   |
|   | Preventive care/screening/immunization           | No Charge   | Not Covered                                     | Includes all preventive care services required by federal and state law.  |
| <b>If you have a test</b>                                     | Diagnostic test (x-ray, blood work)              | No Charge   | Not Covered                                     | —————none—————  |
|   | Imaging (CT/PET scans, MRIs)                     | \$100/test  | Not Covered                                     | —————none—————  |
| <b>If you need drugs to treat your illness or condition</b>   | Generic drugs                                    | \$10 Retail \$25 Mail                                   | Member may have greater out of pocket expenses. | Member pays the difference if purchasing a brand name drug when a generic alternative is available. Brand diabetic supplies available at generic copay. |
|   | Brand name drugs                                 | \$200/\$500   |   |   |
|   | Specialty drugs                                  | Individual/Family Deductible then \$35 Retail \$90 Mail |   |   |
| <b>If you have outpatient surgery</b>                         | Facility fee (e.g., ambulatory surgery center)   | \$100/admit   | Not Covered                                     | —————none—————  |
|   | Physician/surgeon fees                           | No Charge   | Not Covered                                     | —————none—————  |
| <b>If you need immediate medical</b>                          | Emergency room services                          | \$100/visit   | Not Covered                                     | Copayment waived if admitted.   |
|   | Emergency medical transportation                 | \$100/trip  | Not Covered                                     | Must be medically necessary.  |

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Coverage Period: 10/01/2012 – 09/30/2013

Coverage for: Individual/Family | Plan Type: HMO

| Common Medical Event   | Services You May Need                        | Your Cost If You Use an In-network Provider                             | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions  |
|--|--|---|---|---|
| attention  | Urgent care                                  | \$20/visit  | Not Covered                                     | Copayment waived if admitted inpatient or outpatient Emergency Room. For in area, contact your primary care physician or medical group. |
| If you have a hospital stay  | Facility fee (e.g., hospital room)           | \$200/admit   | Not Covered                                     | Preauthorization required.  |
|  | Physician/surgeon fee                        | No Charge   | Not Covered                                     | —————none—————  |
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | <u>Office Visit</u><br>\$20/visit<br><u>Facility Visit</u><br>No Charge | Not Covered                                     | Facility-based subject to preauthorization. Outpatient physician visits subject to pre-service review.                                  |
|  | Mental/Behavioral health inpatient services  | \$200/admit   | Not Covered                                     | Preauthorization required.  |
|  | Substance use disorder outpatient services   | <u>Office Visit</u><br>\$20/visit<br><u>Facility Visit</u><br>No Charge | Not Covered                                     | Facility-based subject to preauthorization. Outpatient physician visits subject to pre-service review.                                  |
|  | Substance use disorder inpatient services    | \$200/admit   | Not Covered                                     | Preauthorization required.  |
| If you are pregnant  | Prenatal and postnatal care                  | \$20/visit  | Not Covered                                     | —————none—————  |
|  | Delivery and all inpatient services          | \$200/admit   | Not Covered                                     | —————none—————  |

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# Anthem Blue Cross: Premier 20/200; Rx 10-35/200

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 10/01/2012 – 09/30/2013

Coverage for: Individual/Family | Plan Type: HMO

| Common Medical Event   | Services You May Need     | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions  |
|--|---------------------------|---|---|---|
| If you need help recovering or have other special health needs | Home health care          | \$20/visit                                  | Not Covered                                     | Limited to 100 visits per calendar year; one visit by a home health aide equals four hours or less.   |
|  | Rehabilitation services   | \$20/visit                                  | Not Covered                                     | Combined limit of 60-days period of care for Physical, Speech, Occupational and Chiropractic therapy. |
|  | Habilitation services     | \$20/visit                                  | Not Covered                                     |   |
|  | Skilled nursing care      | No Charge                                   | Not Covered                                     | Limited to 100 days per calendar year.  |
|  | Durable medical equipment | 20% coinsurance                             | Not Covered                                     | Breast pump and supplies are covered under preventive care at no charge.                              |
|  | Hospice service           | No Charge                                   | Not Covered                                     | —————none—————  |
| If your child needs dental or eye care                         | Eye exam                  | Not Covered                                 | Not Covered                                     | —————none—————  |
|  | Glasses                   | Not Covered                                 | Not Covered                                     | —————none—————  |
|  | Dental check-up           | Not Covered                                 | Not Covered                                     | —————none—————  |

## Excluded Services & Other Covered Services:

| Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.) |  |   |
|---|--|---|
| <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Long-term care</li> </ul>   | <ul style="list-style-type: none"> <li>• Most coverage provided outside the United States. See <a href="http://www.BCBS.com/bluecardworldwide">www.BCBS.com/bluecardworldwide</a></li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine eye care (Adult)</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul> |

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### Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery (must be preauthorized)
- Chiropractic care (combined with other therapy for a limit of 60-days period of care)
- Hearing aids
- Infertility treatment (limited to studies and tests)

### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-825-5541. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

California Department of Managed Health Care Help Center (DMHC business only)  
980 9<sup>th</sup> Street, Suite 500  
Sacramento, CA 95814  
1-888-466-2219  
[www.healthhelp.ca.govhelpline@dmhc.ca.gov](http://www.healthhelp.ca.govhelpline@dmhc.ca.gov)

State of California (CDI business only)  
DEPARTMENT OF INSURANCE  
CLAIMS SERVICE BUREAU  
300 South Spring Street, South Tower  
Los Angeles, CA 90013  
[www.insurance.ca.gov](http://www.insurance.ca.gov)

For additional assistance regarding appeals you may contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

### Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoolwoł íinízinigo t'áá diné k'éjúgo, t'áá shoodí ba na'alníhí ya sidáhí bich'í naabídíłkiid. Eí doo biigha daago ni ba'nija'go ho'aalagú bich'í hodiilní. Hai'daq iini'taago eíya, t'áá shoodí diné ya atáh halne'ígú ní béesh bee hane'í wólta' bíki si'niilígú bí'kéhgo bich'í hodiilní.

아직 가입하지 않았거나 한국어로 된 도움말이 필요한 경우 영업 관리자나 그룹 관리자에게 문의하시기 바랍니다. 이미 가입한 경우 ID 카드에 있는 번호를 사용하여 고객 서비스에 문의하시기 바랍니다.

Nếu quý vị chưa phải là một hội viên và cần được giúp đỡ bằng Tiếng Việt, xin liên lạc với đại diện thương mại của quý vị hoặc quản trị viên nhóm. Nếu quý vị đã ghi danh, xin liên lạc với dịch vụ khách hàng qua việc dùng số điện thoại ghi trên thẻ ID của quý vị.

*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$6840
- Patient pays \$700

#### Sample care costs:

|                            |                |
|----------------------------|----------------|
| Hospital charges (mother)  | \$2,700        |
| Routine obstetric care     | \$2,100        |
| Hospital charges (baby)    | \$900          |
| Anesthesia                 | \$900          |
| Laboratory tests           | \$500          |
| Prescriptions              | \$200          |
| Radiology                  | \$200          |
| Vaccines, other preventive | \$40           |
| <b>Total</b>               | <b>\$7,540</b> |

#### Patient pays:

|                      |              |
|----------------------|--------------|
| Deductibles          | \$0          |
| Copays               | \$500        |
| Coinsurance          | \$0          |
| Limits or exclusions | \$200        |
| <b>Total</b>         | <b>\$700</b> |

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3880
- Patient pays \$1520

#### Sample care costs:

|                                |                |
|--------------------------------|----------------|
| Prescriptions                  | \$2,900        |
| Medical Equipment and Supplies | \$1,300        |
| Office Visits and Procedures   | \$700          |
| Education                      | \$300          |
| Laboratory tests               | \$100          |
| Vaccines, other preventive     | \$100          |
| <b>Total</b>                   | <b>\$5,400</b> |

#### Patient pays:

|                      |               |
|----------------------|---------------|
| Deductibles          | \$200         |
| Copays               | \$1200        |
| Coinsurance          | \$20          |
| Limits or exclusions | \$100         |
| <b>Total</b>         | <b>\$1520</b> |

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact Anthem at 1-800-825-5541.

## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.