

Anthem Blue Cross: 80-M \$40; Rx 15-50/200

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

Coverage Period: 10/01/2013 - 09/30/2014

Coverage for: Individual/Family | Plan Type: PPO



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 or by calling 1-855-333-5730.

| Important Questions | Answers | Why this Matters: |
|---|--|---|
| What is the overall <u>deductible</u> ? | For In and Out-of-Network providers: \$3,500 per individual / \$7,000 per family 4 th Quarter rollover applies | You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> . |
| Are there other <u>deductibles</u> for specific services? | Yes. Brand drugs \$200/\$500 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. For In and Out-of-Network providers: \$2,500 per individual / \$5,000 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, deductibles, costs related to prescription drugs 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. This policy has no overall annual limit on the amount it will pay each year. | 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 www.anthem.com/ca/sisc or call 1-855-333-5730. | 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> ? | No. | You can see the <u>specialist</u> you choose without permission from this plan. |
| Are there services this plan doesn't cover? | Yes. | Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about <u>excluded services</u> . |

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- **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 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 |
|--|--|---|---|--|
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$40/visit | Billed charges exceeding out-of-network fee schedule | Deductible applies to out-of-network. |
| | Specialist visit | \$40/visit | Billed charges exceeding out-of-network fee schedule | Deductible applies to out-of-network. |
| | Other practitioner office visit | <u>Chiropractor</u> 20% coinsurance after deductible <u>Acupuncturist</u> 20% coinsurance after deductible with \$50/visit max | <u>Chiropractor</u> Billed charges exceeding out-of-network fee schedule <u>Acupuncturist</u> 0% coinsurance with \$25/visit max | <u>Chiropractor</u> Medical necessity review is required after the 5 th visit. <u>Acupuncture</u> Coverage is limited to 12 visits, combined in and out-of-network and deductible applies. |
| | Preventive care/screening/immunization | No Cost Share | Not Covered | —————none————— |
| If you have a test | Diagnostic test (x-ray, blood work) | 20% coinsurance after deductible | Billed charges exceeding out-of-network fee schedule | —————none————— |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance after deductible | 0% coinsurance with \$800/test max | Coverage is limited to \$800 for out-of-network providers. |

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| 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 drugs to treat your illness or condition | Typically Generic drugs | \$15 Retail \$40 Mail | Member may have greater out of pocket expense for using a non-preferred provider | Most generics available at Costco for \$0 copayment. |
| | Typically Preferred/Formulary drugs | \$200/\$500 Individual/Family Deductible then \$50 Retail \$135Mail | Member may have greater out of pocket expense for using a non-preferred provider | Brand diabetic supplies available at generic copayment. If the member selects a brand drug when a generic equivalent is available the member is responsible for the generic copayment plus the cost difference between the generic and brand equivalent, even if the physician indicates no substitutions. |
| | Typically Non-preferred/non-formulary drugs | | Member may have greater out of pocket expense for using a non-preferred provider | —————none————— |
| | Typically Specialty drugs | | Member may have greater out of pocket expense for using a non-preferred provider | —————none————— |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | | 20% coinsurance after deductible | <u>Outpatient Facility</u> 50% coinsurance <u>Ambulatory Surgery Center</u> 0% coinsurance with \$350/admission max |

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|--|------------------------------------|--|--|---|
| | Physician/surgeon fees | 20% coinsurance after deductible | Billed charges exceeding out-of-network fee schedule | You are responsible for billed charges exceeding scheduled amount for out-of-network providers. |
| If you need immediate medical attention | Emergency room services | \$100/visit before deductible and 20% coinsurance after deductible | \$100/visit before deductible and 20% coinsurance after deductible | Copayment waived if admitted. You are responsible for billed charges exceeding maximum allowed amount for out-of-network providers. |
| | Emergency medical transportation | 20% coinsurance after deductible | Deductible applies, billed charges exceeding maximum allowed | _____none_____ |
| | Urgent care | \$40/visit | Billed charges exceeding out-of-network fee schedule | Costs may vary by site of service. You should refer to your formal contract of coverage for details. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance after deductible | 0% coinsurance with \$600/day max | Deductible applies to out-of-network. Preauthorization is required. |
| | Physician/surgeon fee | 20% coinsurance after deductible | Billed charges exceeding out-of-network fee schedule | _____none_____ |

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|---|--|--|--|--|
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | <u>Office Visit</u> \$40/visit <u>Facility Visit</u> 20% coinsurance after deductible | <u>Office Visit</u> Billed charges exceeding out-of-network fee schedule <u>Facility Visit</u> 50% coinsurance after deductible | <u>Facility Visit</u> Preauthorization is required. You are responsible for billed charges exceeding maximum allowed amount for out-of-network providers. |
| | Mental/Behavioral health inpatient services | 20% coinsurance after deductible | 0% coinsurance with \$600/day max | Deductible applies to out-of-network. Preauthorization is required. |
| | Substance use disorder outpatient services | <u>Office Visit</u> \$40/visit <u>Facility Visit</u> 20% coinsurance after deductible | <u>Office Visit</u> 0% coinsurance after deductible <u>Facility Visit</u> 50% coinsurance after deductible | <u>Office Visit</u> Deductible waived for in-network providers. You are responsible for billed charges exceeding scheduled amount for out-of-network providers. <u>Facility Visit</u> You are responsible for billed charges exceeding scheduled amount for out-of-network providers. |
| | Substance use disorder inpatient services | 20% coinsurance after deductible | 0% coinsurance with \$600/day max | Deductible applies to out-of-network. Preauthorization is required. |
| If you are pregnant | Prenatal and postnatal care | 20% coinsurance after deductible | Billed charges exceeding out-of-network fee schedule | —————none————— |
| | Delivery and all inpatient services | 20% coinsurance after deductible | 0% coinsurance with \$600/day max | Deductible applies to out-of-network. |

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| 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% coinsurance after deductible | Billed charges exceeding maximum allowed | Coverage is limited to 100 occurrences every 12 months. Preauthorization is required. |
| | Rehabilitation services | 20% coinsurance after deductible | Billed charges exceeding out-of-network fee schedule | All physical medicine services are subject to medical necessity review. |
| | Habilitation services | 20% coinsurance after deductible | Billed charges exceeding out-of-network fee schedule | |
| | Skilled nursing care | 20% coinsurance after deductible | 0% coinsurance with \$600/day max | Coverage is limited to 100 visits per year. Deductible applies to out-of-network. |
| | Durable medical equipment | 20% coinsurance after deductible | Billed charges exceeding out-of-network fee schedule | —————none————— |
| | Hospice service | No Cost Share | 20% coinsurance after deductible | —————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————— |

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Acupuncture (limits apply)
- Bariatric surgery (must be preauthorized and performed at a qualified Center of Medical Excellence Facility)
- Chiropractic care (subject to review for medical necessity)
- Hearing aids (limited to \$700 per 24 months)
- Most coverage provided outside the United States. See www.BCBS.com/bluecardworldwide
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) (as part of routine physical exam)

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 Tulare Foundation 1-800-322-5709; Kern Foundation 1-800-322-5709; Woodland Hills 1-800-825-5541; Coastal TPA 1-800-564-7475. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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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 9th Street, Suite 500

Sacramento, CA 95814

1-888-466-2219

www.healthhelp.ca.gov/helpline@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

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.

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 íínízinigo t'áá diné k'éjígoo, t'áá shoodí ba na'aln'íhí ya sidáhí bich'í naabídííłkiid. Eí doo biigha daago ni ba'nija'go ho'aalagú bich'í hodiilní. Hai'daa iini'taago eíya, t'áá shoodí diné ya atáh halne'ígú ní béesh bee hane'í wólta' bí'ki 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.

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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 \$2440
- Patient pays \$5100

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 |
| Total | \$7,540 |

Patient pays:

| | |
|----------------------|---------------|
| Deductibles | \$3500 |
| Copays | \$600 |
| Coinsurance | \$800 |
| Limits or exclusions | \$200 |
| Total | \$5100 |

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

- Amount owed to providers: \$5,400
- Plan pays \$3200
- Patient pays \$2200

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 |
| Total | \$5,400 |

Patient pays:

| | |
|----------------------|---------------|
| Deductibles | \$400 |
| Copays | \$1700 |
| Coinsurance | \$0 |
| Limits or exclusions | \$100 |
| Total | \$2200 |

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 1-855-333-5730.

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.