Anthem BlueCross
PPO 1500/$35

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 or by calling 1-855-333-5730.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1500** single / **2 members** family for In-Network Provider **$1500** single / **2 members** family for Non-Network Provider Does not apply to In-network Preventive Care, Prescription Drugs, Office Visit Copayments, and In-network Hospice In-Network Provider and Non-Network Provider deductibles are combined. Satisfying one helps satisfy the other.	You must pay all the costs up to the **deductible** amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the **deductible** starts over (usually, but not always, January 1st.) See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	Yes; **$250** per member for Prescription Drug.	You must pay all the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes; In-Network Provider per member: **$5000** 2 member family maximum Non-Network Provider per Member: **$10000** In-Network Provider and Non-Network Provider out-of-pocket are separate and do not count towards each other.	The **out-of-pocket limit** is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for health care expenses.

Important Questions	Answers	Why this Matters:
What is not included in the out-of-pocket limit?	Balance-Billed Charges, Pre-Authorization Penalties, Infertility Treatment Copays, Health Care This Plan Doesn't Cover, Premiums, Costs Related to Prescription Drugs Covered Under the Prescription Drug Plan, Acupuncture, Mental Health and Substance Abuse copayments.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the insurer pays?	No. This policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 3 describes any limits on what the insurer will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.anthem.com/ca** or call **1-855-333-5730** for a list of participating providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Plans use the terms in-network, preferred, or participating to refer to providers in their network.
Do I need a referral to see a specialist?	No, you do not need a referral to see a specialist.	You can see the specialist 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 8. See your policy or plan document for additional information about excluded services.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** 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 Provider** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay per visit	50% coinsurance	Deductible waived for In-Network Providers.
	Specialist visit	$35 copay per visit	50% coinsurance	Deductible waived for In-Network Providers.
	Other practitioner office visit	Chiropractor 40% coinsurance Acupuncturist 40% coinsurance with $30 max per visit	Chiropractor 50% coinsurance with $25 max per visit Acupuncturist 50% coinsurance with $30 max per visit	Chiropractor Coverage is limited to 24 visits per year. Chiropractor visits count towards your physical and occupational therapy limit. Acupuncturist Coverage is limited to 24 visits per year.
	Preventive care/screening/ immunizations	No charge	50% coinsurance	Deductible waived for In-Network Providers.
If you have a test	Diagnostic test (x-ray, blood work)	Lab - Office 40% coinsurance X-Ray - Office 40% coinsurance	Lab - Office 50% coinsurance X-Ray - Office 50% coinsurance	————none————
	Imaging (CT/PET scans, MRIs)	40% coinsurance	50% coinsurance	Coverage is limited to $800 / dayNon-Network. Failure to obtain preauthorization may result in non-coverage or reduced coverage.

Common Medical Event	Services You May Need	Your Cost If You Use a In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.anthem.com/pharmacyinformation/	Tier 1 – Typically Generic	$10 copay/ prescription (retail and mail order)	50% coinsurance	Covers up to a 30 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)
	Tier 2 – Typically Preferred/Formulary Brand	$30 copay/ prescription (retail only) and $60 copay/prescription (mail order only)	50% coinsurance	If the member selects a brand drug when a generic equivalent is available the member is responsible for the generic copay plus the cost difference between the generic and brand equivalent, even if the physician indicates no substitutions.
	Tier 3 – Typically Non-preferred/ non-Formulary Drugs	$50 copay/ prescription (retail only) and $100 copay/prescription (mail order only)	50% coinsurance	————none————
	Tier 4 – Typically Specialty Drugs	30% coinsurance (retail only) with $150 max and 30% coinsurance (mail order only) with $300 max	50% coinsurance	$3500 annual out-of-pocket limit per member ————none————
If you have outpatient Surgery	Facility Fee (e.g., ambulatory surgery center)	40% coinsurance	50% coinsurance	Coverage is limited to $380 / dayNon-Network.
	Physician/Surgeon Fees	40% coinsurance	50% coinsurance	————none————
If you need immediate medical attention	Emergency Room Services	$150 copay and then 40% coinsurance	$150 copay and then 40% coinsurance	This is for the hospital/facility charge only. The ER physician charge may be separate. copay waived if admitted

Common Medical Event	Services You May Need	Your Cost If You Use a In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Emergency Medical Transportation	40% coinsurance	40% coinsurance	————none————
	Urgent Care	$35 copay per visit	50% coinsurance	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)	40% coinsurance	50% coinsurance with $650 max per day	Failure to obtain preauthorization may result in non-coverage or an additional $250 copayment for non-participating providers.
	Physician/surgeon fee	40% coinsurance	50% coinsurance	————none————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit 40% coinsurance Mental/Behavioral Health Facility Visit - Facility Charges 40% coinsurance	Mental/Behavioral Health Office Visit 50% coinsurance with $25 max per visit Mental/Behavioral Health Facility Visit - Facility Charges 50% coinsurance with $175 max per admission	Mental/Behavioral Health Office Visit Coverage is limited to a total of 20 visits, In-Network Provider and Non-Network Provider combined per year; 1 visit per day. Mental/Behavioral Health Facility Visit - Facility Charges Coverage is limited to a total of 30 days, In-Network Provider and Non-Network Provider combined per year (inpatient and outpatient facility-based visits combined). Failure to obtain preauthorization for inpatient and outpatient facility may result in non-coverage or an additional $250 copayment for non-participating providers.
	Mental/Behavioral health inpatient services	40% coinsurance	50% coinsurance with $175 max per day	Coverage is limited to a total of 30 days, In-Network Provider and Non-Network Provider combined per year (inpatient and outpatient facility visits combined).

Common Medical Event	Services You May Need	Your Cost If You Use a In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Substance use disorder outpatient services	Substance Abuse Office Visit 40% coinsurance Substance Abuse Facility Visit - Facility Charges 40% coinsurance	Substance Abuse Office Visit 50% coinsurance with $25 max per day Substance Abuse Facility Visit - Facility Charges 50% coinsurance with $175 max per admission	Substance Abuse Office Visit Substance Abuse visits count towards your mental/behavioral health limit. Substance Abuse Facility Visit - Facility Charges Coverage is limited to a total of 30 days, In-Network Provider and Non-Network Provider combined per yearCoverage is limited to $175 per day Non-Network..
	Substance use disorder inpatient services	40% coinsurance	50% coinsurance	Coverage is limited to $175 per day to Non-Network Provider. Substance abuse visits count towards your mental/behavioral health limit.
If you are pregnant	Prenatal and postnatal care	40% coinsurance	50% coinsurance	Your doctor's charges for delivery are part of prenatal and postnatal care.
	Delivery and all inpatient services	40% coinsurance	50% coinsurance	Coverage is limited to $650 / dayNon-Network.
If you need help recovering or have other special health needs	Home Health Care	40% coinsurance	50% coinsurance	Coverage is limited to 100 visits per year; 1 visit by a home health aide equals four hours or less; limited to $75/visit for non-network. Failure to obtain preauthorization may result in non-coverage or an additional $250 copayment for non-participating providers.
	Rehabilitation Services	40% coinsurance	50% coinsurance	Coverage is limited to 24 visits per year for physical therapy and occupational therapy combined; limited to $25/visit for non-network. Chiropractor visits count towards your physical and occupational therapy limit.
	Habilitation Services	40% coinsurance	50% coinsurance	Habilitation visits count towards your rehabilitation limit.

Common Medical Event	Services You May Need	Your Cost If You Use a In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Skilled Nursing Care	40% coinsurance	50% coinsurance	Coverage is limited to 100 days per year; limited to $150/day for non-network. Failure to obtain preauthorization may result in non-coverage or an additional $250 copayment for non-participating providers.
	Durable medical equipment	50% coinsurance	50% coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Hospice service	No charge	50% coinsurance	————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.)

- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Long- term care
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide.
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care unless you have been diagnosed with diabetes. Consult your formal contract of coverage.
- 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
- Bariatric surgery is covered only for morbid obesity
- Chiropractic care
- Infertility treatment Services are subject to per member lifetime maximum: $2000 Medical Services, and $1500 Prescription Drugs. Consult your formal contract of coverage.

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 1-855-333-5730. You may also contact your state insurance department, the Department of Labor's Employee Benefits
Security Administration
1-866-444-EBSA (3272)
www.dol.gov/ebsa/healthreform.

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:

Anthem BlueCross
ATTN: Appeals
P.O. Box 4310
Woodland Hills, CA 91365-4310

Or Contact:

Department of Labor's Employee Benefits
Security Administration at
1-866-444-EBSA(3272) or
www.dol.gov/ebsa/healthreform

California Department of Insurance
Consumer Services Division
300 South Spring Street, South Tower
Los Angeles, CA 90013
(800) 927-HELP (4357)

Department of Managed Health Care
California Help Center
980 9th Street, Suite 500
Sacramento, CA 95814-2725
1-888-HMO-2219

A consumer assistance program can help you file your appeal. Contact:
California Department of Managed Health Care
Help Center
980 9th Street, Suite 500
Sacramento, CA 95814
(888) 466-2219
http://www.healthhelp.ca.gov
helpline@dmhc.ca.gov

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

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。

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíiłkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

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.

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.

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 mãi 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.

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:** $3,570
- **Patient pays:** $3,970

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:

Total Deductibles	$1,500
Co-pays	$20
Co-insurance	$2,300
Limits or exclusions	$150
Total	**$3,970**

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $2,810
- **Patient pays:** $2,590

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:

Total Deductibles	$1,500
Co-pays	$500
Co-insurance	$510
Limits or exclusions	$80
Total	**$2,590**

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: www.anthem.com/ca or 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, co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.