



**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 1-855-333-5730.

| Important Questions                                       | Answers                                                                                                                              | Why this Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|-----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <u>deductible</u> ?                   | <b>\$3,000</b> Individual/ <b>\$5,200</b> Family                                                                                     | You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> 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 <b>deductible</b> .                                                                                             |
| Are there other <u>deductibles</u> for specific services? | No.                                                                                                                                  | You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.                                                                                                                                                                                                                                                                                                              |
| Is there an <u>out-of-pocket limit</u> on my expenses?    | Yes. For In-Network Providers<br><b>\$5,000</b> Individual/ <b>\$10,000</b> Family                                                   | The <b>out-of-pocket limit</b> 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 and health care this plan doesn't cover.                                                            | Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .                                                                                                                                                                                                                                                                                                                                                                      |
| 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 <b>providers</b> , see <a href="http://www.anthem.com/ca/sisc">www.anthem.com/ca/sisc</a> or call 1-855-333-5730. | If you use an in-network doctor or other health care <b>provider</b> , 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 <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> . |
| Do I need a referral to see a <u>specialist</u> ?         | No.                                                                                                                                  | You can see the <b>specialist</b> 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 <b>excluded services</b> .                                                                                                                                                                                                                                                                                                   |

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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 <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | 10% <b>coinsurance</b>                                                                  | Billed charges exceeding out of network fee schedule.            | -----none-----                                                 |
|                                                               | Specialist visit                                 | 10% <b>coinsurance</b>                                                                  | Billed charges exceeding out of network fee schedule.            | -----none-----                                                 |
|                                                               | Other practitioner office visit                  | Chiropractor;<br>10% <b>coinsurance</b><br><br>Acupuncturist;<br>10% <b>coinsurance</b> | Chiropractic: Not Covered<br>Acupuncture: 50% <b>coinsurance</b> | Acupuncture: Coverage is limited to 12 visits/calendar year.   |
|                                                               | Preventive care/screening/immunization           | No Cost Share                                                                           | Not Covered                                                      | -----none-----                                                 |
| If you have a test                                            | Diagnostic test (x-ray, blood work)              | 10% <b>coinsurance</b>                                                                  | Not Covered                                                      | -----none-----                                                 |
|                                                               | Imaging (CT/PET scans, MRIs)                     | 10% <b>coinsurance</b>                                                                  | Billed charges exceeding out of network fee schedule.            | Coverage limited to \$800 for <b>out-of-network</b> providers. |

# Anthem Blue Cross: HSA-B

Coverage Period: 1/1/2016 – 09/30/2016

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

Coverage for: Individual/Family | Plan Type: HSA

| 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                                                                                                                                                                                                                                                                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <b>prescription drug coverage</b> is available at <a href="https://www.anthem.com/ca/health-insurance/provider-directory/searchcriteria?branding=ABC&amp;provtype=Rx">https://www.anthem.com/ca/health-insurance/provider-directory/searchcriteria?branding=ABC&amp;provtype=Rx</a></p> | Generic drugs ( <i>includes diabetic supplies</i> )                                                            | <p><b>\$0</b> Costco Pharmacy</p> <p><b>\$7</b> Copay/ prescription (retail)</p> <p><b>\$14</b> Copay/ prescription (home delivery)</p> | <b>\$7</b> Copay/ prescription plus <b>50%</b> of the remaining prescription drug maximum allowed amount  | For Non-Participating Pharmacies: Member pays the retail pharmacy copay plus <b>50%</b> . Covers up to a 30 day supply for Retail pharmacy or a 90 day supply for Home Delivery. For Non-Participating Pharmacies, compound drugs & certain specialty pharmacy drugs may require preauthorization or are not covered. |
|                                                                                                                                                                                                                                                                                                                                                                                      | Brand name formulary drugs ( <i>includes self-injectable drugs</i> )                                           | <p><b>\$25</b> Copay/ prescription (retail)</p> <p><b>\$60</b> Copay/ prescription (home delivery)</p>                                  | <b>\$25</b> Copay/ prescription plus <b>50%</b> of the remaining prescription drug maximum allowed amount | 30-day supply; 60-day supply for Federally Classified Schedule II Attention Deficit Disorder drugs that require a triplicate prescription require double copay available only at a Retail Pharmacy.                                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                      | Brand name non-formulary drugs ( <i>includes compound drugs; retail only; includes self-injectable drugs</i> ) | <p><b>\$25</b> Copay/ prescription (retail)</p> <p><b>\$60</b> Copay/ prescription (home delivery)</p>                                  | <b>\$25</b> Copay/ prescription plus <b>50%</b> of the remaining prescription drug maximum allowed amount |                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                      | Specialty drugs ( <i>includes self-injectable drugs</i> )                                                      | <p><b>\$7</b> Copay/ prescription for Generic drugs</p> <p><b>\$25</b> Copay/ prescription for Brand name drugs</p>                     | Not Covered                                                                                               | Certain specialty pharmacy drugs may require a preauthorization or are not covered. Covers up to a 30 day supply for Specialty Pharmacy.                                                                                                                                                                              |

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# Anthem Blue Cross: HSA-B

Coverage Period: 1/1/2016 – 09/30/2016

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

Coverage for: Individual/Family | Plan Type: HSA

| 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 have outpatient surgery          | Facility fee (e.g., ambulatory surgery center) | 10% <u>coinsurance</u>                      | Billed charges exceeding out of network fee schedule. | Coverage is limited to <b>\$350/Admit</b> for Non-Network Ambulatory Surgery Center. Outpatient Facility subject to utilization review                                                                                                                                       |
|                                         | Physician/surgeon fees                         | 10% <u>coinsurance</u>                      | Billed charges exceeding out of network fee schedule. | -----none-----                                                                                                                                                                                                                                                               |
| If you need immediate medical attention | Emergency room services                        | \$100 / visit + 10% <u>coinsurance</u>      | \$100 / visit + 10% <u>coinsurance</u>                | \$100 Copayment waived if admitted. You are responsible for billed charges exceeding maximum allowed amount for <u>out-of-network</u> providers.                                                                                                                             |
|                                         | Emergency medical transportation               | 10% <u>coinsurance</u>                      | 10% <u>coinsurance</u>                                | -----none-----                                                                                                                                                                                                                                                               |
|                                         | Urgent care                                    | 10% <u>coinsurance</u>                      | 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)             | 10% <u>coinsurance</u>                      | 0% <u>coinsurance</u> with \$600/day max              | The maximum <u>plan</u> payment for non-emergency hospital services received from a <u>out-of-network</u> hospital is \$600 per day. Members are responsible for all charges in excess of \$600. Failure to prior authorize may result in reduced or nonpayment of benefits. |
|                                         | Physician/surgeon fee                          | 10% <u>coinsurance</u>                      | Billed charges exceeding out of network fee schedule. | -----none-----                                                                                                                                                                                                                                                               |

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# Anthem Blue Cross: HSA-B

Coverage Period: 1/1/2016 – 09/30/2016

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

Coverage for: Individual/Family | Plan Type: HSA

| 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 have mental health, behavioral health, or substance abuse needs</b> | Mental/Behavioral health outpatient services | 10% <u>coinsurance</u>                      | Billed charges exceeding out of network fee schedule. | -----none-----                                                                                        |
|                                                                               | Mental/Behavioral health inpatient services  | 10% <u>coinsurance</u>                      | Billed charges exceeding out of network fee schedule. | This is for facility professional services only. Please refer to your hospital stay for facility fee. |
|                                                                               | Substance use disorder outpatient services   | 10% <u>coinsurance</u>                      | Billed charges exceeding out of network fee schedule. | -----none-----                                                                                        |
|                                                                               | Substance use disorder inpatient services    | 10% <u>coinsurance</u>                      | Billed charges exceeding out of network fee schedule. | This is for facility professional services only. Please refer to your hospital stay for facility fee. |
| <b>If you are pregnant</b>                                                    | Prenatal and postnatal care                  | 10% <u>coinsurance</u>                      | Billed charges exceeding out of network fee schedule. | -----none-----                                                                                        |
|                                                                               | Delivery and all inpatient services          | 10% <u>coinsurance</u>                      | 0% <u>coinsurance</u> with \$600/day max              | <u>out-of-network</u> facility are subject to a maximum benefit payment up to \$600 per day.          |

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# Anthem Blue Cross: HSA-B

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

Coverage Period: 1/1/2016 – 09/30/2016

Coverage for: Individual/Family | Plan Type: HSA

| 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          | 10% <u>coinsurance</u>                      | Billed charges exceeding out of network fee schedule. | Subject to utilization review. Coverage is limited to a total of 100 visits, In-Network Provider and Non-Network Provider combined per calendar year (one visit by a home health aide equals four hours or less; not covered while insured person receives hospice care). Services from In-Network Provider and Non-Network Provider count towards your limit. |
|                                                                | Rehabilitation services   | 10% <u>coinsurance</u>                      | Not Covered                                           | Costs may vary by site of service. You should refer to your formal contract of coverage for details.                                                                                                                                                                                                                                                           |
|                                                                | Habilitation services     | 10% <u>coinsurance</u>                      | Not Covered                                           | Habilitation visits count toward your rehabilitation visit limit. Costs may vary by site of service. Please refer to your formal contract.                                                                                                                                                                                                                     |
|                                                                | Skilled nursing care      | 10% <u>coinsurance</u>                      | 0% <u>coinsurance</u> with \$600/day max              | Subject to utilization review. Coverage is limited to a combined total of 100 days per calendar year for services received from In-Network & Non-Network Providers. Benefit limited to <b>\$600/Day</b> .                                                                                                                                                      |
|                                                                | Durable medical equipment | 10% <u>coinsurance</u>                      | Not Covered                                           | Subject to utilization review.                                                                                                                                                                                                                                                                                                                                 |
|                                                                | Hospice service           | 10% <u>coinsurance</u>                      | Billed charges exceeding out of network fee schedule. | -----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 (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 (For morbid obesity. Consult your formal contract of coverage)
- Chiropractic care
- Hearing aids (limited to **\$700** per 24 months)
- Most coverage provided outside the United States. See [www.BCBS.com/bluecardworldwide](http://www.BCBS.com/bluecardworldwide)
- 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 1-855-333-5730. 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:

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](http://www.dol.gov/ebsa/healthreform)

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### Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

### Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

### 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 iínizinigo t'áá diné k'éjúgo, t'áá shoodí ba na'alníhí ya sidáhí bich'í naabídíilkiid. Eí doo biigha daago ni ba'nija'go ho'aalagú bich'í hodiilní. Hai'daa iini'taago eíya, t'áá shoodí diné ya atáh halné'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.*



### 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 \$3,830
- Patient pays \$3,710

##### 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          | \$3,000        |
| Copays               | \$10           |
| Coinsurance          | \$500          |
| Limits or exclusions | \$200          |
| <b>Total</b>         | <b>\$3,710</b> |

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

- Amount owed to providers: \$5,400
- Plan pays \$1,990
- Patient pays \$3,410

##### 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          | \$3,000        |
| Copays               | \$300          |
| Coinsurance          | \$10           |
| Limits or exclusions | \$100          |
| <b>Total</b>         | <b>\$3,410</b> |

### 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.