Anthem BlueCross BlueShield
PPO $1,500 S

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:** 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 or by calling 1-855-333-5735.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1500** single / **4500** family for In-Network Provider **$3000** single / **9000** family for Non-Network Provider Does not apply to Preventive Care, Prescription Drugs, and Copayments In-Network Provider and Non-Network Provider deductibles are separate and do not count towards each 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?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes; In-Network Provider Single: **$2500**, Family: **5000** Non-Network Provider Single: **$5000**, Family: **10000**	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.
What is not included in the out-of-pocket limit?	Balance-Billed Charges, Deductibles, Copayments, Pre-Authorization Penalties, Health Care This Plan Doesn't Cover, Premiums, Costs Related to Covered Prescription Drugs.	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.

Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes. See **www.anthem.com** or call **1-855-333-5735** 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 7. 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 participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit	50% coinsurance	——————none——————
	Specialist visit	$50 copay per visit	50% coinsurance	
	Other practitioner office visit	Chiropractic/ Manipulative Therapy $20 copay per visit Acupuncturist $20 copay per visit	Chiropractic/ Manipulative Therapy Not covered Acupuncturist Not covered	Chiropractic/Manipulative Therapy Chiropractic, acupuncture, and massage therapy visits count towards your chiropractic limit. Acupuncturist Chiropractic, Acupuncture and massage therapy visits count towards your chiropractic limit.
	Preventive care/screening/ immunizations	No charge	$50 copay per visit	There may be other levels of cost share that are contingent on how services are provided, please see your formal contract of coverage for a complete explanation.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	Lab - Office No cost share X-Ray - Office $50 copay per day	Lab - Office 50% coinsurance X-Ray - Office 50% coinsurance	Lab - Office Costs may vary by site of service. You should refer to your formal contract of coverage for details. X-Ray - Office Costs may vary by site of service. You should refer to your formal contract of coverage for details.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Costs may vary by site of service. You should refer to your formal contract of coverage for details.
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	$15 copay/ prescription (retail and mail order)	Not covered	Specialty drug network must be used for in-network coverage. Covers up to a 30 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)
	Tier 2	$40 copay/ prescription (retail only) and $80 copay/prescription (mail order only)	Not covered	Specialty drug network must be used for in-network coverage. Covers up to a 30 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)
	Tier 3	$60 copay/ prescription (retail only) and $120 copay/prescription (mail order only)	Not covered	Specialty drug network must be used for in-network coverage. Covers up to a 30 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)
	Tier 4	30% copay (retail only) with $250 max and 30% copay (mail order only) with $500 max	Not covered	Specialty drug network must be used for in-network coverage. Covers up to a 30 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)
If you have outpatient Surgery	Facility Fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Costs may vary by site of service. You should refer to your formal contract of coverage for details.
	Physician/Surgeon Fees	20% coinsurance	50% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency Room Services	$250 copay per visit	$250 copay per visit	——————none——————
	Emergency Medical Transportation	20% coinsurance	20% coinsurance	——————none——————
	Urgent Care	$50 copay per visit	50% coinsurance	——————none——————
If you have a hospital stay	Facility Fee (e.g., hospital room)	$200 copay and then 20% coinsurance	50% coinsurance	Coverage is limited to 30 days per yearfor inpatient rehab. Services from In-Network Provider and Non-Network Provider count towards your limit.
	Physician/surgeon fee	20% 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 $50 copay per visit Mental/Behavioral Health Facility Visit - Facility Charges $50 copay per visit	Mental/Behavioral Health Office Visit 50% coinsurance Mental/Behavioral Health Facility Visit - Facility Charges 50% coinsurance	Mental/Behavioral Health Facility Visit - Facility Charges There may be other levels of cost share that are contingent on how services are provided, please see your formal contract of coverage for a complete explanation.
	Mental/Behavioral health inpatient services	20% coinsurance	50% coinsurance	——————none——————
	Substance use disorder outpatient services	Substance Abuse Office Visit $50 copay per visit Substance Abuse Facility Visit - Facility Charges $50 copay per visit	Substance Abuse Office Visit 50% coinsurance Substance Abuse Facility Visit - Facility Charges 50% coinsurance	Substance Abuse Facility Visit - Facility Charges There may be other levels of cost share that are contingent on how services are provided, please see your formal contract of coverage for a complete explanation.
	Substance use disorder inpatient services	20% coinsurance	50% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	$50 copay	50% coinsurance	Copay applies to initial visit. No charge thereafter. Your doctor's charges for delivery are part of prenatal and postnatal care.
	Delivery and all inpatient services	$200 copay and then 20% coinsurance	50% coinsurance	Applies to inpatient facility. Other cost shares may apply depending on services provided.
If you need help recovering or have other special health needs	Home Health Care	20% coinsurance	Not covered	Coverage is limited to 100 visits per year.
	Rehabilitation Services	20% coinsurance	50% coinsurance	Limitations may vary by site of service. You should refer to your formal contract of coverage for details. Services from In-Network Provider and Non-Network Provider count towards your limit.
	Habilitation Services	20% coinsurance	50% coinsurance	——————none——————
	Skilled Nursing Care	20% coinsurance	50% coinsurance	Coverage is limited to 100 days per yearcombined participating provider and non-participating provider. Services from In-Network Provider and Non-Network Provider count towards your limit.
	Durable medical equipment	20% coinsurance	Not covered	——————none——————
	Hospice service	No cost share	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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (adult)
- Hearing aids except for children up to age 18; 1 every 5 years. Consult your formal contract of coverage.
- Infertility treatment
- Long- term care
- 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
- Chiropractic care
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide.

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 1-855-333-5735. 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.

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:

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

Denver CO 80202
www.dora.state.co.us
303-894-7499

DORA Department of Regulatory Agencies
1560 Broadway, Suite 850

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 adoolwoł 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.

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 a health account-based medical plan. This means your employer provides you with a health account that you can use to help pay for eligible medical expenses such as certain deductibles and coinsurance.

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:** $5,580
- **Patient pays:** $1,960

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	$270
Co-insurance	$40
Limits or exclusions	$150
Total	**$1,960**

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,020
- **Patient pays:** $2,380

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	$620
Co-insurance	$180
Limits or exclusions	$80
Total	**$2,380**

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 or 1-855-333-5735.

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.