Group Health Benefit Plan: Anaheim Union High School District

Coverage Period: 01/01/13-12/31/13

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

Coverage for: 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.pinnacletpa.com** or by calling 1-888-327-7264

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$ 275** / person **$ 825** / family	See the chart starting on page 2 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 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. Maximum In-Network **10%** coinsurance / person. Maximum Out-of-Network **40%** coinsurance / person Up to the first **$12,000** of Eligible Expenses.	The **out-of-pocket limit** 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 out–of–pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover. Also, see SPD for other expenses not included in the **out-of-pocket limit**.	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 plan pays?	Yes. **$2,000,000**	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. For a list of **participating providers**, see **www.pinnacletpa.com** or call 1-888-327-7264.	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. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't 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 4. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-888-327-7264 or visit www.pinnacletpa.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.pinnacletpa.com or call 1-888-327-7264 to request a copy.

- **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	10% coinsurance	40% coinsurance	————————none————————
	Specialist visit	10% coinsurance	40% coinsurance	Same as above
	Other practitioner office visit	Chiropractor: 10% coinsurance	Chiropractor: 40% coinsurance	31 visits / Calendar Year
	Preventive care/screening/immunization	No charge	40% coinsurance	————————none————————
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	40% coinsurance	Paid at PPO level when performed at PPO Hospital
	Imaging (CT/PET scans, MRIs)	10% coinsurance	40% coinsurance	Same as above

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 More information about **prescription drug coverage** is available at Retail www.express-scripts.com	Generic drugs	Retail: $5 copay /prescription Mail Order: $10 copay / prescription	Retail: $5 copay /prescription Mail Order: $10 copay / prescription	Female Oral Contraceptives (Generic) have no copay for retail & mail order. Retail =34 day supply Mail Order = 90 day supply
	Preferred brand drugs	Retail: $15 copay /prescription Mail Order: $30 copay / prescription	Retail: $15 copay /prescription Mail Order: $30 copay / prescription	Female Oral Contraceptives (Generic) have no copay for retail & mail order. Retail =34 day supply Mail Order = 90 day supply
	Non-preferred brand drugs	Retail: $40 copay /prescription Mail Order: $80 copay / prescription	Retail: $40 copay /prescription Mail Order: $80 copay / prescription	Female Oral Contraceptives (Generic) have no copay for retail & mail order. Retail =34 day supply Mail Order = 90 day supply
	Specialty drugs	Same as above	Same as above	Retail =34 day supply Mail Order = 90 day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	——————none——————
	Physician/surgeon fees	10% coinsurance	40% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	$100 copay, then 10% coinsurance	$100 copay, then 10% coinsurance	Copay waived if admitted
	Emergency medical transportation	10% coinsurance	10% coinsurance	To or from nearest appropriate Hospital, Home, Skilled Nursing Facility.
	Urgent care	10% coinsurance	10% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	Pre-certification required
	Physician/surgeon fee	10% coinsurance	40% coinsurance	Same as above

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 mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance	40% coinsurance	Coordinated with MHN Behavioral Health Plan
	Mental/Behavioral health inpatient services	10% coinsurance	40% coinsurance	Coordinated with MHN Behavioral Health Plan. Pre-certification required.
	Substance use disorder outpatient services	10% coinsurance	40% coinsurance	Coordinated with MHN Behavioral Health Plan
	Substance use disorder inpatient services	10% coinsurance	40% coinsurance	Coordinated with MHN Behavioral Health Plan. Pre-certification required.
If you are pregnant	Prenatal and postnatal care	10% coinsurance	40% coinsurance	————————none————————
	Delivery and all inpatient services	10% coinsurance	40% coinsurance	————————none————————
If you need help recovering or have other special health needs	Home health care	10% coinsurance	40% coinsurance	A periodic visit by either a Nurse or Therapist, or up to 4 hours of Home Health Care services. Pre-certification required.
	Rehabilitation services	10% coinsurance	40% coinsurance	————————none————————
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	10% coinsurance	40% coinsurance	Pre-certification required.
	Durable medical equipment	10% coinsurance	40% coinsurance	Pre-certification required for each DME purchase over $1,500 and DME rental over $500 a month.
	Hospice service	10% coinsurance	40% coinsurance	Pre-certification required.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Not Covered
	Glasses	Not Covered	Not Covered	Not Covered
	Dental check-up	Not Covered	Not Covered	Not Covered

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.)**

- Acupuncture
- Cosmetic surgery
- Dental care
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care
- Routine foot care

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.)**

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Weight loss programs

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 1-888-327-7264. 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: Pinnacle at 1-888-327-7264 or www.pinnacletpa.com or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-327-7264

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** $6,635
- **Patient pays** $910

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	$275
Copays	$5
Coinsurance	$480
Limits or exclusions	$150
Total	**$910**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,620
- **Patient pays** $780

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	$275
Copays	$205
Coinsurance	$220
Limits or exclusions	$80
Total	**$780**

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.