Anthem Blue Cross
Anaheim Union High School District HMO H2 Plan

Coverage Period: 01/01/2013 – 12/31/2013

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

Coverage for: Individual/Family| **Plan Type:** HMO

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 1-800-888-8288.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0** single/ **$0** family for In-Network Provider **$0** single/ **$0** family for Non-Network Provider	See the chart on page 2 for your costs for services this plan covers.
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. For In-Network Providers: **$1,000/** Individual; **$2,000/** Two-Party; **$3,000/** Family For Non-Network Providers: **Not Applicable**	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, prescription drug copayments, infertility services costs, and health care this plan doesn't cover.	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?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **in-network providers**, see www.anthem.com/ca or call 1-800-888-8288	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?	Yes.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.

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**.

- **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	$20/visit	Not Covered	——————none——————
	Specialist visit	$35/visit	Not Covered	——————none——————
	Other practitioner office visit	Chiropractor $20/visit Acupuncture $20/visit	Chiropractor Not Covered Acupuncture Not Covered	Chiropractor Coverage is limited to 60-days period of care. Chiropractic visits count towards your physical and occupational therapy limit.
	Preventive care/screening/immunization	No Copay	Not Covered	——————none——————

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 a test	Diagnostic test (x-ray, blood work)	Lab-Office No Charge X-Ray-Office No Charge	Lab-Office Not Covered X-Ray-Office Not Covered	——————none——————
	Imaging (CT/PET scans, MRIs)	$100/test	Not Covered	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.anthem.com/ca	Generic drugs	$5/prescription for retail $10/prescription for home delivery	50% coinsurance for retail and home delivery	Female oral contraceptives (generic and single source brand) have no copay for retail and mail service. Covers up to a 30 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)
	Brand name formulary drugs	$15/prescription for retail $30/prescription for home delivery		If the member selects a brand drug when a generic equivalent is available the member is responsible for the applicable copay plus the cost difference between the generic and brand equivalent. If the physician indicates no substitutions the member is only responsible for the brand copay. Covers up to a 30 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)
	Brand name non-formulary drugs	$40/prescription for retail $80/prescription for home delivery		Certain drugs require preauthorization approval to obtain coverage. Covers up to a 30 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)
	Self-administered injectable drugs, except insulin	Covered at applicable copays	Not Covered	Classified specialty drugs must be obtained through our Specialty Pharmacy Program and are subject to the terms of the program.

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)	No Copay	Not Covered	——————none——————
	Physician/surgeon fees	No Copay	Not Covered	——————none——————

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 immediate medical attention	Emergency room services	$150/visit	$150/visit	Copay waived if admitted inpatient. This is for the hospital/facility charge only. The ER physician charge may be separate.
	Emergency medical transportation	No copay	No copay	——————none——————
	Urgent care	$20/visit	$20/visit	Copay waived if admitted inpatient and outpatient ER. Costs may vary by site of service; waived if admitted. Out-of-Network area only covered when out of area.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Copay	Not Covered	——————none——————
	Physician/surgeon fee	No Copay	Not Covered	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit $20/visit Mental/Behavioral Health Facility Visit-Facility Charges No Charge	Mental/Behavioral Health Office Visit Not Covered Mental/Behavioral Health Facility Visit-Facility Charges Not Covered	Pre-authorization required for facility-based care. Behavioral Health treatment subject to pre-service review for outpatient physician visits. This is for facility professional services only. Please refer to your hospital stay for facility fee.
	Mental/Behavioral health inpatient services	No Copay	Not Covered	
	Substance use disorder outpatient services	Substance Abuse Office Visit $20/ visit Substance Abuse Facility Visit-Facility Charges No Charge	Substance Abuse Office Visit Not Covered Substance Abuse Facility Visit-Facility Charges Not Covered	
	Substance use disorder inpatient services	No Copay	Not Covered	
If you are pregnant	Prenatal and postnatal care	$20/visit	Not Covered	Your doctor's charges for delivery are part of prenatal and postnatal care.
	Delivery and all inpatient services	No Copay	Not Covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	$20/visit	Not Covered	Coverage is limited to 100 visits/calendar year (one visit by a home health aide equals four hours or less).
	Rehabilitation services	$20/visit	Not Covered	Coverage is limited to 60-days period of care for Physical, Occupational, or Speech Therapy. Chiropractic visits count towards your physical and occupational therapy limit. Outpatient speech therapy following injury or organic disease.
	Habilitation services	$20/visit	Not Covered	All Rehabilitation and Habilitation visits count toward your Rehabilitation visit limit.
	Skilled nursing care	No Copay	Not Covered	Coverage is limited to 100 days/calendar year.
	Durable medical equipment	No Copay	Not Covered	Breast pump and supplies are covered under preventive care at no charge for In-network providers.
	Hospice service	No Copay	Not Covered	Benefit covers inpatient or outpatient services for members with up to one year life expectancy and family bereavement services.
If your child needs dental or eye care	Eye exam	No Copay	Not Covered	Routine eye exams are noted under the preventive care section of the benefit summary.
	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)
- Bariatric surgery
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Acupuncture
- Chiropractic care (Limits apply)
- Coverage provided outside the United States. See www.BCBS.com/bluecardworldwide
- Female Sterilization- No copay
- Hearing aids (limits apply)
- Infertility treatment (studies and tests, counseling and consultation)
- Routine eye care (Adult)

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 1-800-888-8288. 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:

Anthem Blue Cross
Grievance and Appeal Management
P. O. Box 4310
Woodland Hills, CA 91367

State Department of Insurance contact information:

California Department of Insurance
300 South Spring St.
Los Angeles, CA 90013
1-800-927-4357
www.insurance.ca.gov

Additionally, a consumer assistance program can help you file your appeal. Contact:

California Department of Managed Care
California Help Center
980 9th St., Suite 500
Sacramento, CA 95814-2725
1-888-466-2219
www.dmhc.ca.gov\
www.healthhelp.ca.gov
helpline@dmhc.ca.gov

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 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.

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.

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** $7,260
- **Patient pays** $280

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	$0
Copays	$130
Coinsurance	$0
Limits or exclusions	$150
Total	**$280**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,920
- **Patient pays** $480

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	$0
Copays	$400
Coinsurance	$0
Limits or exclusions	$80
Total	**$480**

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.