Anthem BlueCross BlueShield
Blue Access® PPO Option D58 / Rx Option 8

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

Coverage Period: 12/01/2013 - 11/30/2014

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 or by calling 1-855-333-5735.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$5000** single / **$10000** family for In-Network Provider **$10000** single / **$20000** family for Non-Network Provider Does not apply to In-Network Preventive Care, Emergency Room Services, Copayments, Hospice and Prescription Drugs 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: **$5000**, Family: **$10000** Non-Network Provider Single: **$20000**, Family: **$40000** 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, Copayments, Health Care This Plan Doesn't Cover, Premiums, Costs Related to Prescription Drugs Covered Under the Prescription Drug Plan, Non-Network Human Organ and Tissue Transplant services .	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** 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 9. 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	$30 copay	30% coinsurance	————none————
	Specialist visit	$60 copay	30% coinsurance	————none————
	Other practitioner office visit	Manipulative Therapy $60 copay Acupuncturist Not covered	Manipulative Therapy 30% coinsurance Acupuncturist Not covered	Manipulative Therapy Coverage is limited to a total of 12 visits, In-Network Provider and Non-Network Provider combined per year. Costs may vary by site of service. You should refer to your formal contract of coverage for details.
	Preventive care/screening/ immunizations	No cost share	30% coinsurance	————none————
If you have a test	Diagnostic test (x-ray, blood work)	Lab - Office No cost share X-Ray - Office No cost share	Lab - Office 30% coinsurance X-Ray - Office 30% 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)	0% coinsurance	30% coinsurance	————none————

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/	Typically Generic Drugs	$10 copay/ prescription (retail and mail order)	50% coinsurance (retail only) with $70 minimum per script	If the member selects a brand drug when a generic equivalent is available the member is responsible for the generic copay + 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)
	Typically Preferred/Formulary Drugs	$35 copay/ prescription (retail only) and $88 copay/prescription (mail order only)	50% coinsurance (retail only) with $70 minimum per script	If the member selects a brand drug when a generic equivalent is available the member is responsible for the generic copay + 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)
	Tier 3 – Typically Non-preferred/ Non-formulary and Specialty Drugs	$70 copay/ prescription (retail only) and $175 copay/prescription (mail order only)	50% coinsurance (retail only) with $70 minimum per script	If the member selects a brand drug when a generic equivalent is available the member is responsible for the generic copay + 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)

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
	Tier 4 – Typically Specialty Drugs	25% coinsurance with $200 max and 25% coinsurance (mail order only) with $200 max	50% coinsurance (retail only) with $70 minimum per script	If the member selects a brand drug when a generic equivalent is available the member is responsible for the generic copay + 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) $2500 annual out-of-pocket limit per member (Specialty drug network must be used for in-network coverage.)
If you have outpatient Surgery	Facility Fee (e.g., ambulatory surgery center)	0% coinsurance	30% coinsurance	————none————
	Physician/Surgeon Fees	0% coinsurance	30% coinsurance	————none————
If you need immediate medical attention	Emergency Room Services	$300 copay	$300 copay	copay waived if admitted
	Emergency Medical Transportation	0% coinsurance	0% coinsurance	————none————
	Urgent Care	$75 copay	30% coinsurance	————none————
If you have a hospital stay	Facility Fee (e.g., hospital room)	0% coinsurance	30% coinsurance	Physical medicine and rehabilitation services (including day rehabilitation programs) are limited to 60 days of care regardless of the provider's network status.
	Physician/surgeon fee	0% coinsurance	30% coinsurance	————none————

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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit $60 copay Mental/Behavioral Health Facility Visit - Facility Charges 0% coinsurance	Mental/Behavioral Health Office Visit 30% coinsurance Mental/Behavioral Health Facility Visit - Facility Charges 30% coinsurance	Mental/Behavioral Health Office Visit Coverage is limited to 30 visits per yearIn-Network. Non-Network coverage is limited to 10 visits annual max.. Outpatient and office services count towards the limit. Limitations and cost shares may vary by site of service. You should refer to your formal contract of coverage for details. Behavioral health and substance abuse care count towards your day or visit limit.
	Mental/Behavioral health inpatient services	0% coinsurance	30% coinsurance	Coverage is limited to 30 days per yearIn-Network and Non-Network and reflects room and board and professional services.. Behavioral health and substance abuse care count towards your day or visit limit.
	Substance use disorder outpatient services	Substance Abuse Office Visit $60 copay Substance Abuse Facility Visit - Facility Charges 0% coinsurance	Substance Abuse Office Visit 30% coinsurance Substance Abuse Facility Visit - Facility Charges 30% coinsurance	Substance Abuse Office Visit Coverage is limited to 30 visits per yearIn-Network. Non-Network coverage is limited to 10 visits annual max.. Outpatient and office services count towards the limit. Limitations and cost shares may vary by site of service. You should refer to your formal contract of coverage for details. Behavioral health and substance abuse care count towards your day or visit limit. Substance Abuse Facility Visit - Facility Charges Alcoholism outpatient (non-network) limited to 10 visits.

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 inpatient services	0% coinsurance	30% coinsurance	Coverage is limited to 30 days per yearand reflects room and board and professional services. Behavioral health and substance abuse care both count towards your day or visit limit. Alcoholism Inpatient (non-network) limited to 1 day. Inpatient and outpatient substance abuse rehabilitation programs are limited to 1 episode per benefit period (Network and Non-Network). Services from In-Network Provider and Non-Network Provider count towards your limit.
If you are pregnant	Prenatal and postnatal care	0% coinsurance	30% coinsurance	Your doctor's charges for delivery are part of prenatal and postnatal care.
	Delivery and all inpatient services	0% coinsurance	30% 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	0% coinsurance	30% coinsurance	Coverage is limited to 100 visits per yearDoes not include I.V. therapy. Services from In-Network Provider and Non-Network Provider count towards your limit.
	Rehabilitation Services	$60 copay	30% coinsurance	Coverage for physical therapy is limited to 20 visits per year, occupational therapy is limited to 20 visits per year, speech therapy is limited to 20 visits per year, cardiac rehabilitation is limited to 36 visits per year, and pulmonary rehabilitation is limited to 20 visits per year. Outpatient and office services count towards the limit. Limitations and cost shares 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.

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
	Habilitation Services	0% coinsurance	30% coinsurance	Costs may vary by site of service. You should refer to your formal contract of coverage for details. Habilitation visits count towards your Rehabilitation limit.
	Skilled Nursing Care	0% coinsurance	30% coinsurance	Coverage is limited to a total of 90 days, In-Network Provider and Non-Network Provider combined per year. Services from In-Network Provider and Non-Network Provider count towards your limit.
	Durable medical equipment	0% coinsurance	30% coinsurance	————none————
	Hospice service	No cost share	No cost share	————none————
If your child needs dental or eye care	Eye exam	$30 copay	30% coinsurance	Coverage is for vision exam only. Consult your formal contract of coverage. Costs may vary by site of service. You should refer to your formal contract of coverage for details.
	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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Infertility treatment
- Long- term care
- 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.)

- Chiropractic care
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide.
- Private-duty nursing Limited to $50,000 per benefit period with a lifetime max of $100,000
- Routine eye care (adult) for vision exam only. 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 1-855-333-5735. 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 BlueShield
ATTN: Appeals
P.O. Box 105568
Atlanta, GA 30348-5568

Or Contact:

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

Ohio Department of Insurance
50 West Town Street,
Third Floor, Suite 300
Columbus, OH 43215
800-686-1526 or 614-644-2673

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.

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:** $2,420
- **Patient pays:** $5,120

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	$5,000
Co-pays	$0
Co-insurance	$0
Limits or exclusions	$120
Total	**$5,120**

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $320
- **Patient pays:** $5,080

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	$5,000
Co-pays	$0
Co-insurance	$0
Limits or exclusions	$80
Total	**$5,080**

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.