Anthem Blue Cross
CalPERS Traditional HMO

Coverage Period: 01/01/2016 – 12/31/2016

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/calpers/hmo or by calling 1-855-839-4524.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For In-Network Providers: **$0** Individual/ **$0** Family	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No	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 Medical Services/Expenses:** For In Network HMO Providers: **$1,500** Single**/ $3,000** Family **No Out Of Pocket Limit** when using Non-HMO Providers. **For Pharmacy/Prescription Expenses:** **$5,350** Individual/**$10,700** Family/Mail order **$1,000**	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 with participating providers. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Infertility services, Premiums, Balance-Billed Charges, 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.
Does this plan use a network of providers?	Yes. Anthem Blue Cross Traditional HMO www.anthem.com/ca/calpers/hmo or call 1-855-839-4524 for a list.	You will choose a primary care physician (PCP) who is part of an Anthem Blue Cross Traditional HMO contracting *medical group*.

Do I need a referral to see a specialist?	Yes, unless the specialist is in the "Direct Access" or "Speedy Referral" Programs.	Specialist medical care will not be covered without a referral or PCP/Medical Group authorization.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. 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 **Provider** 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	**$15** Copay/Visit	Not Covered	——----------------none----------------
	Specialist visit	**$15** Copay/Visit	Not Covered	——----------------none----------------
	Other practitioner office visit	Chiropractic & Acupuncture **$15** Copay/Visit	Not Covered	Chiropractic Care & Acupuncture Rider Plan 20 Visits per calendar year combined for Chiropractic & Acupuncture.
	Preventive care/screening /immunization	No Cost Share	Not Covered	——----------------none----------------
If you have a test	Diagnostic test (x-ray, blood work)	Lab & X-Ray-Office No Cost Share	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
	Imaging (CT/PET scans, MRIs)	No Cost Share	Not Covered	—-----------------none----------------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com/calpers	Generic drugs	**$5**/30 day supply **$10**/90 day supply	Not Covered **100%** Out of Pocket	After second fill you will pay the appropriate mail service copay for maintenance medications. 90 day supplies allowed at CVS Stores and CVS/caremark Mail Order.
	Brand name formulary drugs	**$20**/30 day supply **$40**/90 day supply	Not Covered **100%** Out of Pocket	After second fill you will pay the appropriate mail service copay for maintenance medications. 90 day supplies allowed at CVS Stores and CVS/caremark Mail Order.
	Brand name non-formulary drugs	**$50**/30 day supply **$100**/90 day supply	Not Covered **100%** Out of Pocket	After second fill you will pay the appropriate mail service copay for maintenance medications. 90 day supplies allowed at CVS Stores and CVS/caremark Mail Order.
	Specialty drugs	Specialty follows the tier structure above	Not Covered **100%** Out of Pocket	Certain Specialty Medications are available only through CVS/caremark Specialty Pharmacy and are limited up to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center, ASC)	No Cost Share	Not Covered	—----------------none----------------
	Physician/surgeon fee	No Cost Share	Not Covered	—-----------------none-------------------—
If you need immediate medical attention	Emergency room services	**$50** Copay/Visit	**$50** Copay/Visit	This is for the hospital/facility charge only copay waived if admitted inpatient from the ER.
	Emergency medical transportation	No Cost Share	No Cost Share	-------------------none-----------------
	Urgent care	**$15** Copay/Visit	**$15** Copay/Visit	Out-of-network only covered when out of area. For in area, contact your PCP or medical group.

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 hospital stay	Facility fee (e.g., hospital room)	No Cost Share	Not Covered	--------------------none------------------
	Physician/surgeon fees	No Cost Share	Not Covered	—-----------------none--------------------—
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit **$15** Copay/Visit Mental/Behavioral Health Facility Visit-Facility Charges No Cost Share	Mental/Behavioral Health Office Visit Not Covered Mental/Behavioral Health Facility Visit-Facility Charges Not Covered	--------------------none------------------
	Mental/Behavioral health inpatient services	No Cost Share	Not Covered	This is for facility professional services only. Please refer to your hospital benefit.
	Substance use disorder outpatient services	Substance Abuse Office Visit **$15** Copay/Visit Substance Abuse Facility Visit-Facility Charges No Cost Share	Substance Abuse Office Visit Not Covered Substance Abuse Facility Visit-Facility Charges Not Covered	--------------------none------------------
	Substance use disorder outpatient services	No Cost Share	Not Covered	This is for facility professional services only. Please refer to your hospital benefit.
If you are pregnant	Prenatal and postnatal care	No Cost Share	Not Covered	—-----------------none--------------------—
	Delivery and all inpatient services	No Cost Share	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	No Cost Share	Not Covered	**$15**/visit for Physical Therapy, Occupational, Speech, or Respiratory Therapies at home.
	Rehabilitation services	**$15** Copay/Visit	Not Covered	Coverage for Occupational, Physical and Speech therapy.
	Habilitation services	**$15** Copay/Visit	Not Covered	Coverage for Occupational, Physical and Speech therapy.
	Skilled nursing care	No Cost Share	Not Covered	Coverage is limited to 100 days per calendar year.
	Durable medical equipment	No Cost Share	Not Covered	--------------------none-----------------
	Hospice service	No Cost Share	Not Covered	——----------------none-------------------—
If your child needs dental or eye care	Eye exam	No Cost Share	Not Covered	——----------------none-------------------—
	Glasses	No Cost Share	Not Covered	——----------------none-------------------—
	Dental check-up	No Cost Share	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

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 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.)

- Bariatric surgery (For morbid obesity. Consult your formal contract of coverage)
- Hearing Aids (1 per ear/every 3 years)
- 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, maybe 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 1-877-737-7776. 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 1-855-839-4524 P.O. Box 60007 Los Angeles, CA 90060-0007 Attn: CalPERS Grievance and Appeal Management
Additionally, a consumer assistance program can help you file your appeal.
Contact: California Department of Managed Health Care Help Center
980 9th Street, Suite 500 Sacramento, CA 95814
(888) 466-2219 http://www.healthhelp.ca.gov helpline@dmhc.ca.gov

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 adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídííłkiid. Eí doo biigha daago ni ba'nija'go ho'aalagíí 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.

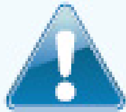
아직 가입하지 않았거나 한국어로 된 도움말이 필요한 경우 영업 관리자나 그룹 관리자에게 문의하시기 바랍니다. 이미 가입한 경우 ID 카드에 있는 번호를 사용하여 고객 서비스에 문의하시기 바랍니다.

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** $7,380
- **Patient pays** $160

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	$10
Coinsurance	$0
Limits or exclusions	$150
Total	**$160**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,970
- **Patient pays** $430

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	$350
Coinsurance	$0
Limits or exclusions	$80
Total	**$430**

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.