Anthem Blue Cross Life and Health Insurance Company
Auxiliary Organizations Association Modified Premier PPO 500/20/80/60

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:** 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 https://eoc.anthem.com/eocdps/ca/fi or by calling 1-855-333-5730.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For In-Network Providers **$500** Single/**$1,000** Family For Non-Network Providers **$500** Single/**$1,000** Family Does not apply to In-Network Hospice, Preventive Care, Primary Care Visit and Specialist Visit. In-Network Provider and Non-Network Provider deductibles are combined. Satisfying one helps satisfy the other.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). 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. For In-Network Providers **$3,500** Single/**$7,000** Family For Non-Network Providers **$3,500** Single/**$7,000** Family In-Network Provider and Non-Network Provider out-of-pocket are combined. Satisfying one helps satisfy the other.	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.	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.

Important Questions	Answers	Why this Matters:
Does this plan use a <u>network</u> of <u>providers</u>?	Yes. See www.anthem.com/ca or call 1-855-333-5730 for a list of In-Network Providers.	If you use an in-network doctor or other health care **<u>provider</u>**, 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 **<u>provider</u>** for some services. Plans use the term in-network, **<u>preferred</u>**, or participating for **<u>providers</u>** in their **<u>network</u>**. See the chart starting on page 2 for how this plan pays different kinds of **<u>providers</u>**.
Do I need a referral to see a <u>specialist</u>?	No. You don't need a referral to see a specialist.	You can see the **<u>specialist</u>** 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 8. See your policy or plan document for additional information about **<u>excluded services</u>**.

- **<u>Copayments</u>** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **<u>Coinsurance</u>** is *your* share of the costs of a covered service, calculated as a percent of the **<u>allowed amount</u>** for the service. For example, if the plan's **<u>allowed amount</u>** for an overnight hospital stay is $1,000, your **<u>coinsurance</u>** payment of 20% would be $200. This may change if you haven't met your **<u>deductible</u>**.
- The amount the plan pays for covered services is based on the **<u>allowed amount</u>**. If an out-of-network **<u>provider</u>** charges more than the **<u>allowed amount</u>**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **<u>allowed amount</u>** is $1,000, you may have to pay the $500 difference. (This is called **<u>balance billing</u>**.)
- This plan may encourage you to use In-Network **<u>providers</u>** by charging you lower **<u>deductibles</u>**, **<u>copayments</u>** and **<u>coinsurance</u>** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	**$20** Copay/Visit	**40%** Coinsurance	--------none--------
	Specialist visit	**$20** Copay/Visit	**40%** Coinsurance	--------none--------
	Other practitioner office visit	Chiropractor **$20** Copay/Visit Acupuncturist **$20** Copay/Visit	Chiropractor **40%** Coinsurance Acupuncturist **40%** Coinsurance	Chiropractor Coverage is limited to 30 visit per Benefit Period combined In-Network and Non-Network Providers. Acupuncturist Coverage is limited to 20 visit per Benefit Period combined In-Network and Non-Network Providers.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Preventive care/screening/ immunization	No Cost Share	**40%** Coinsurance	--------none--------
If you have a test	Diagnostic test (x-ray, blood work)	Lab - Office **20%** Coinsurance X-Ray - Office **20%** Coinsurance	Lab - Office **40%** Coinsurance X-Ray - Office **40%** Coinsurance	--------none--------
	Imaging (CT/PET scans, MRIs)	**20%** Coinsurance	**40%** Coinsurance	Coverage is limited to **$800** maximum per Test for Non-Network Providers. Costs may vary by site of service. You should refer to your formal contract of coverage for details.

Common Medical Event	Services You May Need	Your Cost If You Use an 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 **https://www.anthem.com/ca/health-insurance/provider-directory/searchcriteria?branding=ABC&provtype=Rx**	Tier1 - Typically Generic	**$5** Copay/Prescription for Retail Pharmacy and Home Delivery	**$5** Copay/Prescription plus **50%** of the remaining Prescription Drug maximum allowed amount and costs in excess of the Prescription Drug maximum allowed amount	30 day supply for Retail Pharmacy. 90 day supply for Home Delivery.
	Tier2 - Typically Preferred / Brand	**$20** Copay/Prescription for Retail Pharmacy **$40** Copay/Prescription for Home Delivery	**$20** Copay/Prescription plus **50%** of the remaining Prescription Drug maximum allowed amount and costs in excess of the Prescription Drug maximum allowed amount	30 day supply for Retail Pharmacy. 90 day supply for Home Delivery. If a member requests a Brand Name Drug when a Generic Drug version exists, the member pays the Generic Drug Copay plus the difference in cost between the Prescription Drug maximum allowed amount for the Generic Drug and the Brand Name Drug dispensed, but not more than 50% of our average cost of that type of Prescription Drug. The Preferred Generic Program does not apply when the physician has specified "dispense as written" (DAW) or when it has been determined that the Brand Name Drug is medically necessary for the member. In such case, the applicable Copay for the dispensed Drug will apply.
	Tier3 - Typically Non-Preferred / Specialty Drugs	**$60** Copay/Prescription for Retail Pharmacy **$120** Copay/Prescription for Home Delivery	**$60** Copay/Prescription plus **50%** of the remaining Prescription Drug maximum allowed amount and costs in excess of the Prescription Drug maximum allowed amount	

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Tier4 - Typically Specialty Drugs	**20%** Coinsurance up to **$150** per Prescription for Retail Pharmacy **20%** Coinsurance up to **$300** per Prescription for Home Delivery	**20%** Coinsurance up to **$150** per Prescription plus **50%** of the remaining Prescription Drug maximum allowed amount and costs in excess of the Prescription Drug maximum allowed amount	30 day supply for Retail Pharmacy. 30 day supply for Home Delivery. Classified Specialty Drugs must be obtained through our Specialty Pharmacy Program and are subject to the terms of the Program.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**20%** Coinsurance	**40%** Coinsurance	Coverage is limited to **$350** maximum per Admission for Non-Network Providers.
	Physician/surgeon fees	**20%** Coinsurance	**40%** Coinsurance	--------none--------
If you need immediate medical attention	Emergency room services	**$50** Copay/Admission then **20%** Coinsurance	**$50** Copay/Admission then **20%** Coinsurance	This is for the hospital/facility charge only. The ER physician charge may be separate; copay waived if admitted.
	Emergency medical transportation	**20%** Coinsurance	**20%** Coinsurance	--------none--------
	Urgent care	**$20** Copay/Visit	**40%** Coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	**20%** Coinsurance	**40%** Coinsurance	**$250** per Admission penalty applies if preauthorization is not obtained for Non-Network Providers. Coverage is limited to **$1,000** maximum per Day for Non-Network Providers. Apply to Non-Emergency admission.
	Physician/surgeon fee	**20%** Coinsurance	**40%** Coinsurance	--------none--------

Common Medical Event	Services You May Need	Your Cost If You Use an 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 **$20** Copay/Visit Mental/Behavioral Health Facility Visit - Facility Charges **20%** Coinsurance	Mental/Behavioral Health Office Visit **40%** Coinsurance Mental/Behavioral Health Facility Visit - Facility Charges **40%** Coinsurance	--------none--------
	Mental/Behavioral health inpatient services	**20%** Coinsurance	**40%** Coinsurance	This is for facility professional services only. Please refer to your hospital stay for facility fee.
	Substance use disorder outpatient services	Substance Abuse Office Visit **$20** Copay/Visit Substance Abuse Facility Visit - Facility Charges **20%** Coinsurance	Substance Abuse Office Visit **40%** Coinsurance Substance Abuse Facility Visit - Facility Charges **40%** Coinsurance	--------none--------
	Substance use disorder inpatient services	**20%** Coinsurance	**40%** Coinsurance	This is for facility professional services only. Please refer to your hospital stay for facility fee.
If you are pregnant	Prenatal and postnatal care	**$20** Copay/Visit	**40%** Coinsurance	In-Network Preventive Prenatal and Postnatal services covered at **100%.**
	Delivery and all inpatient services	**20%** Coinsurance	**40%** Coinsurance	**$250** per Admission penalty applies if preauthorization is not obtained for Non-Network Providers. Coverage is limited to **$1,000** maximum per Day for Non-Network Providers. Apply to Non-Emergency admission.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	**20%** Coinsurance	**40%** Coinsurance	Coverage is limited to 100 visit per Benefit Period combined In-Network and Non-Network Providers.
	Rehabilitation services	**20%** Coinsurance	**40%** Coinsurance	Coverage is limited to **$350** maximum per Admission for Physical/Speech/Occupational Therapy for Non-Network Providers. Coverage is limited to **$350** maximum per Admission for Cardiac Rehabilitation for Non-Network Providers. Costs may vary by site of service. You should refer to your formal contract of coverage for details.
	Habilitation services	**20%** Coinsurance	**40%** Coinsurance	Habilitation visits count towards your Rehabilitation limit. Costs may vary by site of service. You should refer to your formal contract of coverage for details.
	Skilled nursing care	**20%** Coinsurance	**40%** Coinsurance	Coverage is limited to 100 day per Benefit Period combined In-Network and Non-Network Providers.
	Durable medical equipment	**20%** Coinsurance	**40%** Coinsurance	--------none--------
	Hospice service	No Cost Share	**40%** 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.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (Unless you have been diagnosed with diabetes.)
- 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
- Bariatric surgery (For morbid obesity, consult your formal contract of coverage.)
- 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 1-855-333-5730. 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 Life and Health Insurance Company
ATTN: Appeals or Grievance
P.O. Box 4310
Woodland Hills, CA 91367

Or Contact:

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

California Department of Insurance
Consumer Communications Bureau Health Unit
300 South Spring Street, South Tower
Los Angeles, CA 90013
(800) 927-HELP (4357)
(800) 482-4833 TDD
www.insurance.ca.gov

A consumer assistance program can help you file your appeal. Contact:
Consumer Communications Bureau Health Unit
300 South Spring Street, South Tower
Los Angeles, CA 90013
(800) 927-HELP (4357)
(800) 482-4833 TDD
www.insurance.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'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:** $5,850
- **Patient pays:** $1,690

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	$500
Copays	$30
Coinsurance	$1,010
Limits or exclusions	$150
Total	**$1,690**

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,190
- **Patient pays:** $1,210

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	$500
Copays	$390
Coinsurance	$240
Limits or exclusions	$80
Total	**$1,210**

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.