

Welcome to the City of Reedley's 2015 Open Enrollment

The **City of Reedley's** 2015 open enrollment is October 14th – November 15th with benefits beginning January 1, 2015.

Good News! The rate increases this year from SJVIA Anthem Blue Cross and Kaiser are below market trends. The increase for Anthem Blue Cross increase is 1.14% and the increase for Kaiser is 4.72%. This low increase is very beneficial to you and the City. Your new payroll deductions will start in December 2014 for January 2015 premiums. The new deduction amounts are provided with the open enrollment packet.

2015 Benefit Modifications are a result of the Affordable Care Act; these changes are reflected below:

- **Anthem Blue Cross HMO and PPO:**
 - Medical Copays will go towards your out of pocket maximum
 - Prescription Drug out of pocket maximums are \$2,000 for an Individual and \$4,000 for a Family; which is separate from your medical out of pocket.
- **Kaiser:**
 - Prescription Drug Copays will go towards your Medical out of pocket maximum of \$1,500 for an Individual and \$3,000 for a Family

2014 Benefit Plans did not have a maximum out of pocket for prescription drugs.

Open Enrollment is the time to change plans, add or drop family members, or to enroll yourself and eligible dependents if you previously waived. Outside of this open enrollment period, the only opportunity to enroll yourself and/or your dependents is if there is an involuntary loss of coverage. For example, if you are covered under your spouse's employer group plan and the coverage is cancelled due to termination of employment, divorce or death, you may enroll on to our group benefits within 30 days of the loss of coverage. Newly eligible dependents through marriage, birth or adoption, can be added within 30 days of eligibility.

How to access your open enrollment packet? Please click on the open enrollment link in the email to access the open enrollment packet. The packet has the Summary of Benefits for Anthem Blue Cross HMO & PPO, Kaiser Benefit Summary, your employee's contribution sheet and all forms necessary to make changes.

Your Responsibility – Must be completed by November 15, 2014

- If you do not want to make any changes **no paperwork is needed.**
- If you want to add a dependent - please complete the enrollment/change form for the appropriate insurance company; check the enrollment change box.
- To change insurance companies you will need to complete the enrollment form and check the open enrollment box for the insurance plan that you want to move to.
- If you want to drop your coverage or your dependents coverage:
 - Anthem Blue Cross members please complete the personal information (name & address) and the waiver section of the enrollment/change form.
 - Kaiser members please complete the waiver form.

Questions:

- Questions regarding enrollment – Please contact Darla Bello at extension 240
- Benefit and/or insurance plan questions please contact Kathy Sunday, Skye Emerson or Susan Smithson at Horstmann Financial & Insurance Services at 559-447-3965.

City of Reedley
San Joaquin Valley Insurance Authority (SJVIA)

Effective January 1, 2015

	SJVIA HMO	SJVIA HMO	SJVIA PPO	
	Anthem Blue Cross HMO 15	Kaiser HMO 15	Anthem Blue Cross PPO Classic 500/35/80/60	
	In Network Only	In Network Only	In Network	Out of Network
Deductible Individual/Family	None	None	\$500 Individual/\$1,000 Family (Combined)	
Maximum Out of Pocket Individual	\$1,000	\$1,500	\$3,000	\$10,000
Maximum Out of Pocket Family	\$2,000	\$3,000	\$6,000	\$20,000
Physicians Services				
Office Visit	\$15	\$15	\$35 copy (Ded Waived)	40% after Deductible
In Patient Visit	No Charge	No Charge	20% after Deductible	40% after Deductible
Urgent Care Visit	\$15	\$15	20% after Deductible	40% after Deductible
Allergy Testing	No Charge	\$15	20% after Deductible	40% after Deductible
Allergy Treatment	No Charge	No Charge	20% after Deductible	40% after Deductible
Vision Exam	\$15	No Charge	No Covered	
Lab & X-Ray	No Charge	No Charge	Other Diagnostic X-ray & Lab - No Copay	40% after Deductible
CT or CAT, PET scan, & MRI	No Charge	Some procedures may require a copay	20% after Deductible	40% after Deductible
Hospital Inpatient	No Charge	No Charge	\$250/admission + 20% after deductible	40% after Deductible/ Additional \$250 copay (Benefit limited to \$600/day)
Outpatient Surgery				
Hospital	No Charge	\$15	20% after deductible plus \$125 copay	40% after Deductible (Benefit limited to \$350 per day)
Ambulatory Surgery Center	No Charge	\$15	20% after Deductible	
ER Charge	\$100	\$50	\$100 Copay (waived if admit), then 20% after deductible	
Ambulance	No Charge	No Charge	20% after Deductible	40% after Deductible
Chiropractor/Acupuncturist	\$10 copay/\$40 visit combined Chiropractic appliances \$50 per calendar year	Not Covered	\$25 copay (Ded waived) 12 visit/cal year	40% after Deductible Maximum of 12 visits/cal year (combined with in network)
Generic	\$10	\$5	\$10	N/A
Formulary Drugs	\$20	\$20	\$20	N/A
Non Formulary Drugs	\$35	\$20	\$35	N/A
	2015 Benefit Modifications	2015 Benefit Modifications	2015 Benefit Modifications	
	<ul style="list-style-type: none"> •Medical Copays will go toward out of pocket •RX will have a Maximum Out of Pocket of \$2000/4000 	<ul style="list-style-type: none"> •RX Copays go towards the Out of Pocket Maximum 	<ul style="list-style-type: none"> •Medical Copays will go toward out of pocket •RX will have a Maximum Out of Pocket of \$2000/4000 	

The above benefit comparisons are provided as a courtesy of Horstmann Financial and Insurance Services and are for discussion purposes only. Please refer to the EOC provided by the carrier to verify benefits. Horstmann Financial and Insurance Services is clear of any liability for any errors that may occur in the transference of information.

All Active Employees

Total Cost	Employee Only	Employee + 1	Employee + 2 or more
SJVIA PPO	\$556.82	\$1,112.64	\$1,446.34
SJVIA HMO	\$521.61	\$1,042.22	\$1,354.79
SJVIA Kaiser	\$646.38	\$1,275.81	\$1,653.67
City's Contribution	Employee Only	Employee + 1	Employee + 2 or more
Blended PPO & HMO	\$539.22	\$1,077.43	\$1,400.57
Employee Contribution	Employee Only	Employee + 1	Employee + 2 or more
SJVIA PPO	\$17.60	\$35.21	\$45.77
SJVIA HMO	\$0.00	\$0.00	\$0.00
SJVIA Kaiser	\$107.16	\$198.38	\$253.10



Anthem Blue Cross Enrollment Form

Please return the completed enrollment form to your employer.

Employer Notice: After your review of the enrollment form for completeness, please fax or mail the form to:

Anthem Blue Cross
PO Box 629
Woodland Hills, CA 91365-0629
Fax no.: 877-363-1077
Email Address: CALGEnrollintake@wellpoint.com

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anthem.com/ca
GC4050 Rev. 8/13

Anthem Blue Cross Enrollment Form

Effective date: 01 0 1 1 5
Group no.:



Purpose: New enrollment Re-hire Part-time to full-time **Open enrollment** Family addition Change COBRA Cal-COBRA

SECTION 1: TYPE OF COVERAGE – Select from only the coverages offered by your employer

MEDICAL

Anthem Blue Cross plans:

- HMO (CaliforniaCare)*
- Preferred HMO (CaliforniaCare PLUS)*
- Advantage HMO*
- Select HMO*
- Priority Select HMO*
- Other: _____
- PPO (Prudent Buyer)
- Advantage PPO
- EPO (Prudent Buyer Exclusive)
- POS (Blue Cross Plus)*
- Medicare

Anthem Blue Cross Life and Health Insurance Company plans:

- CareAdvocate PPO
- Select PPO
- BC PPO (non-California resident)
- BC Exclusive (non-California resident)
- BC CareAdvocate PPO (non-California resident)
- Lumenos®
- (select one of the following)
- H.S.A.** H.R.A.
- H.I.A. H.I.A. Plus
- ACO Flex*

* Indicate Medical Group/IPA No. in the *Employee and Family Information* section.

** Anthem Blue Cross will facilitate the opening of a Health Savings Account in your name, if directed by your employer.

DENTAL

Anthem Blue Cross plans:

- Dental Net HMO*
- Choice Dental (select one of the following)
- Dental Net HMO* PPO Dental
- Other: _____

Anthem Blue Cross Life and Health Insurance Company plans:

- Dental Blue PPO
- PPO Dental
- Voluntary PPO Dental
- National Dental Blue PPO
- National PPO Dental
- National Voluntary PPO Dental

* Indicate Dental Office No. in the *Employee and Family Information* section.

~~Unl Account (Flexible Spending account)*~~
(Indicate payroll deductions)

- I authorize payroll deductions on the following:
- Health Care Account \$ _____
 - Dependent Care \$ _____

~~* Anthem Blue Cross PPO, drug and dental plan enrollees, will have out of pocket expenses, automatically deducted from their Health Care FSA account. Automatic FSA processing is not possible for HMO enrollees and those with coverage through another health plan. Reminder: Automatic FSA processing is the equivalent of signing and submitting an FSA claim form, which states that you are eligible for FSA reimbursement and that you will not claim FSA reimbursed expenses on your income tax return.~~

VISION Blue View Vision (offered by Anthem Blue Cross Life and Health Insurance Company)

LIFE INSURANCE

All the coverages listed may not be offered under your plan. To elect dependent coverage, the corresponding employee coverage must be selected.

List all life insurance beneficiaries in the *Life Insurance Beneficiary Designation Information* section.

Annual salary

\$ _____

Elected Benefit	Benefit Amount	Elected Benefit	Benefit Amount	Elected Benefit	Benefit Amount
<input type="checkbox"/> Basic Life (AD&D)	\$ _____	<input type="checkbox"/> Optional Life – Employee	\$ _____	<input type="checkbox"/> Optional AD&D – Employee	\$ _____
<input type="checkbox"/> Dependent Life – Spouse	\$ _____	<input type="checkbox"/> Optional Dependent Life/Spouse	\$ _____	<input type="checkbox"/> Optional AD&D – Spouse	\$ _____
<input type="checkbox"/> Dependent Life – Child	\$ _____	<input type="checkbox"/> Optional Dependent Life/Child	\$ _____	<input type="checkbox"/> Optional AD&D – Child	\$ _____
		<input type="checkbox"/> Short Term Disability	\$ _____	<input type="checkbox"/> Voluntary Short Term Disability	\$ _____
		<input type="checkbox"/> Long Term Disability	\$ _____	<input type="checkbox"/> Voluntary Long Term Disability	\$ _____

LANGUAGE CHOICE (optional) English Spanish Chinese Korean Other – please specify: _____

SECTION 2: APPLICANT'S PERSONAL INFORMATION

Social security numbers are required under CMS Regulations

Last name	First name	M.I.	Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner (DP)	Social security or ID no. (required)
Street address			Apt. no. # of dependents including spouse	Spouse/DP social security or ID no.
City		State	ZIP code	Home phone no.
Hire date/Rehire date	Employer name	Job title	Class	Dept. no.
Email address				

SECTION 3: EMPLOYEE AND FAMILY INFORMATION – Please list yourself and all eligible family members to be enrolled. Attach additional sheets if necessary.

Sex	Last Name	First Name	M.I.	Birthdate (MM/DD/YYYY)	If children are age 26 or over you must check the appropriate boxes below	HMO, POS & ACO ONLY IPA/Primary Care Physician Code	Current MD?	Dental Net ONLY Office No.
<input type="checkbox"/> M <input type="checkbox"/> F	Employee						<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> M <input type="checkbox"/> F	Spouse/DP				IRS Qualified Dependent		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	

To be eligible as a Domestic Partner, the Subscriber and Domestic Partner must have properly filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to the California Family Code, or have properly filed an equivalent document in accordance with the laws of another jurisdiction recognizing the creation of domestic partnerships.

SECTION 4: DECLINATION – To be completed if any coverage is declined or refused by an eligible employee and/or their eligible dependents

<p>A. Medical coverage declined for: <input type="checkbox"/> Myself <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren)</p> <p>B. Dental coverage declined for: <input type="checkbox"/> Myself <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren)</p> <p>C. Vision coverage declined for: <input type="checkbox"/> Myself <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren)</p> <p>D. Life insurance coverage declined for: <input type="checkbox"/> Myself <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren)</p>	<p>Reason for declining coverage – check one</p> <p><input type="checkbox"/> Covered by spouse's group coverage. Carrier name and ID no.: _____</p> <p><input type="checkbox"/> Covered by Anthem Blue Cross Individual policy</p> <p><input type="checkbox"/> Spouse covered by employer's group medical coverage. Carrier name: _____</p> <p><input type="checkbox"/> Enrolled in Tricare</p> <p><input type="checkbox"/> Enrolled in any other insurance carrier plan. Carrier name: _____</p> <p><input type="checkbox"/> Medicare</p> <p><input type="checkbox"/> Other (Explain): _____</p>
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I acknowledge that the available coverages have been explained to me by my employer and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage. **BY DECLINING THIS GROUP MEDICAL COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL COVERAGE ELSEWHERE) I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UP TO TWELVE (12) MONTHS TO BE ENROLLED IN THIS GROUP MEDICAL AND/OR GROUP LIFE INSURANCE PLAN.**

Signature if declining coverage for employee/dependent(s) X	Date
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SECTION 5: COBRA/CAL-COBRA COVERAGE INFORMATION – Complete only if enrolling in COBRA/Cal-COBRA

Reason for COBRA/Cal-COBRA coverage _____

Federal COBRA qualifying event date	Federal COBRA coverage begin date	Federal COBRA coverage end date
Cal-COBRA qualifying event date	Cal-COBRA coverage begin date	Cal-COBRA coverage end date

SECTION 6: OTHER COVERAGE FOR ALL ENROLLING EMPLOYEES AND DEPENDENTS – All questions must be answered

~~A. Do any persons on this application intend to continue other group coverage if this application is accepted? Yes No~~
 If yes, name of person: _____ Insurance company: _____

~~B. Does any person applying for coverage currently have health insurance coverage? Yes No~~
~~Has any person applying for coverage had health insurance coverage at any time in the past six months? Yes No~~
 If yes, applicant/family member name(s): _____
 Type of continuous coverage: Group Individual Other: _____
 Insurance company: _____ Date coverage began: _____ Date ended: _____

~~C. Does any person applying for coverage currently have dental insurance coverage? Yes No~~
 If yes, applicant/family member name(s): _____
 Type of continuous coverage: Group Individual Other: _____
 Insurance company: _____ Date coverage began: _____ Date ended: _____

~~D. Is any person applying for coverage eligible for Medicare or currently receiving Medicare benefits? Yes No~~
Note: If you are eligible for Medicare, Anthem Blue Cross may not duplicate Medicare benefits.

SECTION 7: MEDICARE SECTION – Complete if you, your spouse or dependent child(ren) have Medicare coverage. Attach additional sheets if necessary.

Name	Part A Effective Date	Part B Effective Date	Reason for Disability if Under Age 65	Medicare Claim No.

SECTION 8: PRIOR COVERAGE FOR PPO PLANS ONLY – Attach additional sheets if necessary

Please fill out the following information to receive proper credit for **PREVIOUS COVERAGE** (if immediately prior to becoming eligible for this plan, you have a dependent child(ren) over the age of 26 who cannot get a self-sustaining job due to a physical or mental condition and was covered under any public or private health care coverage, including MediCal or individual coverage). **NOTE:** If this section is left blank, there may be delays in the processing of claims for these dependents.

Name	Coverage Begin Date	Coverage End Date	Carrier Name	Reason for Ending Coverage
Child				

SECTION 9: LIFE INSURANCE BENEFICIARY DESIGNATION INFORMATION

~~Note: Dependent Life payments are always paid to the employee.~~

~~Primary Beneficiary — First to receive payment (required) — If more than one beneficiary is named, enter a % for each. If no percentage is shown, equal shares are assumed.~~

Name	Birthdate	Social security no.	Relationship	%
Street address		City	State	ZIP code
Name	Birthdate	Social security no.	Relationship	%
Street address		City	State	ZIP code

SECTION 10: PLEASE READ CAREFULLY — Signature required

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

DEDUCTION AUTHORIZATION: If applicable, I authorize my employer to deduct from my wages the required subscription charges/premiums.

NON-PARTICIPATING PROVIDER: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

EFFECTIVE DATE: The effective date of coverage is subject to Anthem Blue Cross approval.

COBRA/CAL-COBRA CONTINUATION COVERAGE

You may continue your health care coverage by: 1) completing the remainder of this form; 2) signing your name in the blank space below; 3) paying your Total Monthly Continuation Payment; and 4) mailing this form to Anthem Blue Cross, no later than sixty (60) days after the date you receive this notice. If you fail to choose COBRA Continuation Coverage within sixty (60) days after the date you receive this notice, your qualification for coverage will end. If you do choose COBRA Continuation Coverage, your current coverage will be continued until the earliest of the following dates:

- 1 The date eligibility for COBRA Continuation Coverage ends, or
- 2 The date you fail to make timely payments of your premium for COBRA Continuation Coverage, or
- 3 The date your employer discontinues coverage with Anthem Blue Cross, or
- 4 The date you become entitled to Medicare on the basis of age (65 years), or the date thirty (30) months after you become entitled to Medicare on the basis of end stage renal disease, or
- 5 The date you become covered under another group health plan as a result of employment, re-employment, remarriage, or otherwise.

If, at any time during the first sixty (60) days of your COBRA Continuation Coverage, you are determined under Title II or XVI of the United States Social Security Act to be disabled, you may be entitled to continue coverage while you are disabled for up to 29 months from the date you first qualified for Continuation Coverage under COBRA. Contact the Health Plan Administrator at your previous employer for full information.

The Monthly Continuation Payment is the cost of continued coverage for the month beginning on the date after the Date of Loss of Coverage. If you do not pay your initial monthly premium within 45 days after your election of COBRA Continuation Coverage, or if payment of succeeding premiums are not received within the 30-day grace period thereafter, your coverage will end.

Note: If you do not elect available COBRA Continuation of Medical Coverage, you will lose certain rights under federal law (HIPAA) to guaranteed issue individual coverage.

REQUIREMENT FOR BINDING ARBITRATION

IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. It is understood that any dispute including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and as provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL AND PARTICIPATION IN A CLASS ACTION FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.

Signature (Required)

Applicant	Date
X	



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 <http://www.anthem.com/ca> or by calling 1-800-888-8288.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0	See the chart starting 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 <u>out-of-pocket limit</u> on my expenses?	Yes. For In-Network Providers \$1,000 Individual/ \$2,000 Family For Out-of-Network Providers \$0 Individual/ \$0 Family	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 <u>out-of-pocket limit</u> ?	Infertility Services Copay, Prescription Drugs Copay, 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 <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See http://www.anthem.com/ca or call 1-800-888-8288 for a list of In-Network 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. 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 <u>specialist</u> ?	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 6. See your policy or plan document for additional information about excluded services .

Questions: Call 1-800-888-8288 or visit us at <http://www.anthem.com/ca>.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://www.anthem.com/ca> or call 1-800-888-8288 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	\$15 Copay/Visit	Not Covered	-----none-----
	Specialist visit	\$15 Copay/Visit	Not Covered	-----none-----
	Other practitioner office visit	Chiropractor \$15 Copay/Visit Acupuncturist \$15 Copay/Visit	Chiropractor Not Covered Acupuncturist Not Covered	Chiropractor Coverage is limited to 60 days period of care for Physical, Occupational, or Speech Therapy or Chiropractic care. Chiropractic visits count towards your physical and occupational therapy limit. Chiropractor & Acupuncture Rider 40 additional Chiropractic and Acupuncture combined visits per Benefit Period: \$10 Copay/Visit.
	Preventive care/screening/immunization	No Cost Share	Not Covered	-----none-----

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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 Cost Share X-Ray – Office No Cost Share	Lab – Office Not Covered X-Ray – Office Not Covered	-----none-----
	Imaging (CT/PET scans, MRIs)	No Cost Share	Not Covered	Costs may vary by site of service. You should refer to your formal contract of coverage for details.
If you need drugs to treat your illness or condition	Tier 1 - Typically Generic	Not Covered	Not Covered	Carved out to another vendor
	Tier 2 - Typically Preferred/Formulary Brand	Not Covered	Not Covered	
	Tier 3 - Typically Non-preferred/Non-formulary Drugs	Not Covered	Not Covered	
	Tier 4 - Typically Specialty Drugs	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Cost Share	Not Covered	-----none-----
	Physician/surgeon fees	No Cost Share	Not Covered	-----none-----
If you need immediate medical attention	Emergency room services	\$100 Copay/Visit	Covered as In-Network	This is for the hospital/facility charge only. The ER physician charge may be separate; copay waived if admitted inpatient.
	Emergency medical transportation	No Cost Share	Covered as In-Network	-----none-----
	Urgent care	\$15 Copay/Visit	Covered as In-Network	Copay waived if admitted inpatient or outpatient ER. Out-of-network only covered when out of area. For in area, contact your PCP or medical group. Costs may vary by site of service. You should refer to your formal contract of coverage for details.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Cost Share	Not Covered	-----none-----
	Physician/surgeon fee	No Cost Share	Not Covered	-----none-----

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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	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 stay for facility fee.
	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 inpatient services	No Cost Share	Not Covered	This is for facility professional services only. Please refer to your hospital stay for facility fee.
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-----

Questions: Call 1-800-888-8288 or visit us at <http://www.anthem.com/ca>.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://www.anthem.com/ca> or call 1-800-888-8288 to request a copy.

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	\$15 Copay/Visit	Not Covered	Coverage is limited to 100 visits per benefit period; one visit by a home health aide equals four hours or less.
	Rehabilitation services	\$15 Copay/Visit	Not Covered	Coverage is limited to 60 days period of care for Physical, Occupational, or Speech Therapy or Chiropractic care. Costs may vary by site of service. You should refer to your formal contract of coverage for details.
	Habilitation services	No Cost Share	Not Covered	Services received in a Hospital, other than Emergency Room Services, or in any facility that is affiliated with a Hospital. 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	No Cost Share	Not Covered	Coverage is limited to 100 days per benefit period.
	Durable medical equipment	No Cost Share	Not Covered	-----none-----
	Hospice service	No Cost Share	Not Covered	Inpatient or outpatient services; family bereavement services.
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-----

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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)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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.)

- Acupuncture
- Bariatric surgery (For morbid obesity, consult your formal contract of coverage.)
- Chiropractic care
- Hearing aids (Coverage is limited to one Hearing aid per ear every three years.)
- Infertility Treatment

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.

Questions: Call 1-800-888-8288 or visit us at <http://www.anthem.com/ca>.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://www.anthem.com/ca> or call 1-800-888-8288 to request a copy.

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
ATTN: Appeals or Grievance
P.O. Box 4310
Woodland Hills, CA 91367

Department of Managed Health Care
California Help Center
980 9th Street, Suite 500
Sacramento, CA 95814-2725
1-888-HMO-2219

Or Contact:

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

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.**

Questions: Call 1-800-888-8288 or visit us at <http://www.anthem.com/ca>.

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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 adoolwol íinízinigo t'áá diné k'éjúgo, t'áá shoodí ba na'alníhí ya sidáhí bich'í naabídílkúid. Eí doo biigha daago ni ba'nija'go ho'aalagí bich'í hodiilní. Hai'daą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígú ní béesh bee hane'í wólta' bí'ki si'núiligí bí'kéhgo bich'í 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 mại 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.

Questions: Call 1-800-888-8288 or visit us at <http://www.anthem.com/ca>.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://www.anthem.com/ca> or call 1-800-888-8288 to request a copy.

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: \$7,370
- Patient pays: \$170

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	\$0
Coinsurance	\$0
Limits or exclusions	\$170
Total	\$170

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

- Amount owed to providers: \$5,400
- Plan pays: \$2,320
- Patient pays: \$3,080

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:

Deductibles	\$0
Copays	\$150
Coinsurance	\$0
Limits or exclusions	\$2,930
Total	\$3,080

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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.

Questions: Call 1-800-888-8288 or visit us at <http://www.anthem.com/ca>.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://www.anthem.com/ca> or call 1-800-888-8288 to request a copy.



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 <http://www.anthem.com/ca> or by calling 1-800-888-8288.

Important Questions	Answers	Why this Matters:
<p>What is the overall <u>deductible</u>?</p>	<p>For PPO Providers: \$500 Member/\$1,000 Family For Non-PPO Providers: \$500 Member/\$1,000 Family Does not apply to Preventive Care, Office Visit Copayments, Hospice and Prescription Drugs. PPO Provider and Non-PPO Provider deductibles are combined.</p>	<p>You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u>.</p>
<p>Are there other <u>deductibles</u> for specific services?</p>	<p>Yes. \$250/Admission for Non-Anthem Blue Cross PPO Hospital or Residential Treatment Center; waived for Emergency admission. \$250/Admission for Non-Anthem Blue Cross PPO Hospital or Residential Treatment Center if utilization review not obtained; waived for Emergency admission. \$100/Visit for Emergency Room Services, waived if admitted directly from ER.</p>	<p>You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.</p>
<p>Is there an <u>out-of-pocket limit</u> on my expenses?</p>	<p>For PPO Providers \$3,000 Individual/Year \$6,000 Family/Year For Non-PPO Providers: \$10,000 Individual/ Year 20,000 Family/Year PPO Provider and Non-PPO Provider out-of-pocket are separate and do not count towards each other.</p>	<p>The <u>out-of-pocket limit</u> 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.</p>

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What is not included in the <u>out-of-pocket limit</u>?	Premiums, Balance-billed charges and Health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u>?	Yes. See http://www.anthem.com/ca or call 1-800-888-8288 for a list of PPO 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> .



- **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 PPO **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO 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	\$35 Copay/Visit	40% Coinsurance	-----none-----
	Specialist visit	\$35 Copay/Visit	40% Coinsurance	-----none-----

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Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
	Other practitioner office visit	Chiropractor \$25 Copay/Visit Acupuncturist 20% Coinsurance	Chiropractor 40% Coinsurance Acupuncturist 40% Coinsurance	Chiropractor Coverage is limited to 12 visits per calendar year. Additional visits maybe authorized. Services from In-Network and Non-Network providers count towards your calendar limit. Acupuncture Coverage is limited to 20 visits with for In-Network and Non-Network Providers/per calendar year.
	Preventive care/screening/immunization	No Cost Share	40% Coinsurance	-----none-----
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office 0% Coinsurance X-Ray – Office 0% Coinsurance	Lab – Office 40% Coinsurance X-Ray – Office 40% Coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	40% Coinsurance	Subject to utilization review. Costs may vary by site of service. You should refer to your formal contract of coverage for details.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available	Tier 1 - Typically Generic	Not Covered	Not Covered	Carved out to another vendor.
	Tier 2 - Typically Preferred/Formulary Brand	Not Covered	Not Covered	
	Tier 3 – Typically Non-preferred/Non-formulary Drugs	Not Covered	Not Covered	
	Tier 4 -Typically Specialty Drugs	Not Covered	Not Covered	

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Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$125 Copay/Surgery plus 20% Coinsurance	40% Coinsurance	Coverage is limited to \$350/Day for Non-PPO Providers.
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	-----none-----
If you need immediate medical attention	Emergency room services	20% Coinsurance	20% Coinsurance	Additional deductible of \$100 applies, waived if admitted in patient. This is for the hospital/facility charge only. The ER physician charge may be separate.
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	-----none-----
	Urgent care	\$35 Copay/Visit	40% Coinsurance	Costs may vary by site of service. You should refer to your formal contract of coverage for details.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 Copay/ Admission plus 20% Coinsurance	40% Coinsurance	\$250 /admission deductible applies for Non-Anthem Blue Cross PPO hospitals or residential treatment centers; waived for emergency admissions. Failure to obtain utilization review will result in an additional \$250 deductible for Non-Anthem PPO hospitals or residential treatment centers; waived for emergency admissions. Subject to utilization review for inpatient services and certain outpatient services; waived for emergency admissions. Coverage is limited to \$600/day per calendar year for Non-PPO providers.
	Physician/surgeon fee	20% Coinsurance	40% Coinsurance	-----none-----

Questions: Call 1-800-888-8288 or visit us at <http://www.anthem.com/ca>.

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Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
<p>If you have mental health, behavioral health, or substance abuse needs</p>	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit \$35 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 \$35 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.

Questions: Call 1-800-888-8288 or visit us at <http://www.anthem.com/ca>.

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Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	20% Coinsurance	40% Coinsurance	-----none-----
	Delivery and all inpatient services	\$250 Copay/ Admission plus 20% Coinsurance	40% Coinsurance	\$250 /admission deductible applies for Non-Anthem Blue Cross PPO hospitals; waived for emergency admissions. Failure to obtain utilization review will result in an additional \$250 deductible for Non-Anthem PPO hospitals; waived for emergency admissions. Subject to utilization review for inpatient services and certain outpatient services; waived for emergency admissions. Coverage is limited to \$600 /day per calendar year for Non-PPO providers.

Questions: Call 1-800-888-8288 or visit us at <http://www.anthem.com/ca>.

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Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	20% Coinsurance	Subject to utilization review. Coverage is limited to a total of 100 visits, In-Network Provider and Non-Network Provider combined per benefit period (one visit by a home health aide equals four hours or less; not covered while member receives hospice care). Services from In-Network Provider and Non-Network Provider count towards your limit.
	Rehabilitation services	\$25 Copay/Visit Speech Therapy \$35 Copay/Visit	40% Coinsurance	-----none-----
	Habilitation services	\$25 Copay/Visit	40% Coinsurance	-----none-----
	Skilled nursing care	20% Coinsurance	20% Coinsurance	Subject to utilization review. Coverage is limited to a combined total of 100 days per benefit period for services received from In-Network & Non-Network Providers.
	Durable medical equipment	20% Coinsurance	20% Coinsurance	-----none-----
	Hospice service	0% Coinsurance	0% Coinsurance	Subject to utilization review.
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-----

Questions: Call 1-800-888-8288 or visit us at <http://www.anthem.com/ca>.

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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.)

- Acupuncture
- Bariatric surgery (For morbid obesity, consult your formal contract of coverage.)
- Chiropractic care
- Hearing aids (Coverage is limited to one Hearing aid per ear every three 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 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 1-800-662-5502. 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.

Questions: Call 1-800-888-8288 or visit us at <http://www.anthem.com/ca>.

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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
ATTN: Appeals or Grievance
P.O. Box 4310
Woodland Hills, CA 91367

Department of Managed Health Care
California Help Center
980 9th Street, Suite 500
Sacramento, CA 95814-2725
1-888-HMO-2219

Or Contact:

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

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

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 ei dooda'i, shikaa adoolwol iin'izinigo t'aa diné k'éjügo, t'aa shoodí ba na'alnihí ya sidáhi bich'i naabidíilkiid. Eí doo biigha daago ni ba'nija'go ho'aalagíi bich'i hodiilni. Hai'daq iini'taago eíya, t'aa shoodí diné ya atáh halne'igíi ní béesh bee hane'i wólta' bi'ki si'nüligíi bi'kéhgo bich'i hodiilni.

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 mại 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.*—————

Questions: Call 1-800-888-8288 or visit us at <http://www.anthem.com/ca>.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://www.anthem.com/ca> or call 1-800-888-8288 to request a copy.

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: \$6,250
- Patient pays: \$1,290

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	\$250
Coinsurance	\$370
Limits or exclusions	\$170
Total	\$1,290

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

- Amount owed to providers: \$5,400
- Plan pays: \$1,470
- Patient pays: \$3,930

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	\$290
Coinsurance	\$210
Limits or exclusions	\$2,930
Total	\$3,930

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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.

Questions: Call 1-800-888-8288 or visit us at <http://www.anthem.com/ca>.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://www.anthem.com/ca> or call 1-800-888-8288 to request a copy.

California Region Group Enrollment/Change Form

Please print or type in black ink only. See instructions on reverse before completing this form. Make a copy for your records.

TO BE COMPLETED BY EMPLOYER		
Company name		Hire date (mm/dd/yyyy)
Group number	Enrollment unit	Effective enrollment/ change date (mm/dd/yyyy)

A. ENROLLMENT/CHANGE REASON (see Change Table for assistance) New group: Yes No

New Hire (complete sections A, B, C, D) Open Enrollment (complete sections A, B, C, D)

Health Plan (Check one) HMO Plan Deductible Plan Other _____

Loss of Other Coverage (complete sections A, B, C, D) Other (please specify) _____

Name Change (complete sections A, B, C, D) From: _____ To: _____

Event Date (mm/dd/yyyy) _____

B. EMPLOYEE Have you ever been a Kaiser Permanente member? Yes No

Medical Record No. (if known) _____ Social Security No. _____

Name (Last, First, MI) _____ Birth Date (mm/dd/yyyy) _____ Gender M F

Home Address _____ City _____ State _____ ZIP _____

Work Phone _____ Home Phone _____ Email _____

Ethnicity _____ Preferred Language _____

C. FAMILY For additional dependents, attach a separate sheet with employee's name at top. (Last, First, MI)

<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
Spouse/domestic partner name: Former last name (if any):		
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Child <input type="checkbox"/> Student	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
Dependent name: Relationship:		
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Child <input type="checkbox"/> Student	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
Dependent name: Relationship:		
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Child <input type="checkbox"/> Student	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
Dependent name: Relationship:		

Do any of dependents above live at another address? Yes No If yes, complete the following:

Name (Last, First, MI): _____ Address: _____

D. Kaiser Foundation Health Plan, Inc., and Kaiser Permanente Insurance Company Arbitration Agreement*

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation, or any claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), Kaiser Permanente Insurance Company (KPIC),* any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP or coverage by KPIC, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage and in the Certificate of Insurance.

*Disputes arising from any of the following KPIC products are not subject to binding arbitration: 1) Tiers 2 & 3 of the Point-of-Service (POS) Plan; 2), the Preferred Provider Organization (PPO) and Out-of-Area Indemnity (OOA) Plans; and 3), the KPIC Dental Plans.

Signature Required for all Kaiser Permanente Plans
(Excluding KPIC PPO, KPIC OOA, and KPIC Dental Plans)

Date



California Region Group Enrollment/Change Form

General instructions

1. Please print firmly and legibly in black ink.
2. To enroll, the subscriber must reside or work within one of the ZIP codes listed on the enclosed sheet.
3. The employer must complete the first section titled "To be completed by employer."
4. The employer is responsible for confirming all information prior to submitting, especially effective dates, as these affect your Health Plan dues.
5. The employee/subscriber must complete Sections A and B. See right column for detailed instructions.
6. Be sure to sign and date the bottom of the form.
7. Once the form is complete (including employer section), the subscriber should make a copy for his or her records, and to use as a temporary ID card, after the effective date.
8. All changes to accounts, including effective dates and child or student status, will be made in accordance with the contractual agreement between the purchaser and Kaiser Permanente.

Instructions for completing employer and new enrollment sections and sections A through D:

To be completed by employer: The employer must complete all fields to ensure we have correct account and enrollment information.

Section A: The subscriber must complete this section.

Section B: The subscriber must always complete this section. Use the Change Table (below) for assistance.

Section C: The subscriber must indicate the requested change to the account and complete all fields for any dependents being enrolled. We will verify the eligibility of these dependents during the enrollment process. Be sure to include any former last names for both spouses and dependents. Also indicate the appropriate role. The student role should be marked only if the dependent qualifies as an "overage dependent" attending school. Please contact your employer regarding rules for overage dependent students. A completed *Student Certification* form may be required.

Section D: The subscriber must sign and date this section.

Change Table

Add dependent

	Event date
Acquired student status*	Student status date
Family adoption*	Adoption date
Loss of coverage	Coverage loss date
New spouse (marriage)	Marriage date
Moved into service area	Move date
Newborn addition	Birth date
Open enrollment	Open enrollment effective date

Delete dependent

	Event date
Loss of student status	Status change date
Divorce	Divorce date
Member deceased*	Death date
Delete dependent(s)	Dependent termination date
Open enrollment	Open enrollment effective date

Demographic Change

	Event date
Address change, telephone number change	Status change date
Demographic (name, birthdate, social security number) change	Status change date

*Additional documentation may be required.

* Due to Kaiser's system issues, the 2015 Kaiser SBC is not available yet. There were no changes to the plan except for the pharmacy out-of-pocket maximums.

Kaiser Permanente: TRADITIONAL PLAN

Coverage Period: 01/01/2014-12/31/2014

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

Coverage for: 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.kp.org or by calling 1-800-278-3296.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0	See 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. \$1,500 Individual/\$3,000 Family * 2015 - Pharmacy co-pays go towards these maximums.	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, health care this plan doesn't cover, and cost sharing for certain services listed in plan documents.	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 <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of plan providers , see www.kp.org or call 1-800-278-3296.	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 , but you may self-refer to certain specialists.	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 5. See your policy or plan document for additional information about excluded services .

Questions: Call 1-800-278-3296 or 1-800-777-1370 (TTY), or visit us at www.kp.org.

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.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-800-278-3296 or 1-800-777-1370 (TTY) to request a copy.

SJVIA-CITY OF REEDLEY

PID:604207 CNTR:0 EU:N/A Plan ID:526 SBC ID:96366



- **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 **plan providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Plan Provider	Non-Plan Provider	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$15 per visit	Not Covered	—————none—————
	Specialist visit	\$15 per visit	Not Covered	Services related to infertility covered at 50% coinsurance per visit.
	Other practitioner office visit	\$15 per visit for acupuncture services.	Not Covered	Chiropractic care not covered. Physician referred acupuncture.
	Preventive care/ screening/ immunization	No Charge	Not Covered	Some preventive screenings (such as lab and imaging) may be at a different cost share.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: No Charge; Lab tests: No Charge	Not Covered	—————none—————
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	—————none—————

* Due to Kaiser's system issues, the 2015 Kaiser SBC is not available yet. There were no changes to the plan except for the pharmacy out-of-pocket maximums.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Plan Provider	Non-Plan Provider	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/formulary .	Generic drugs	Plan pharmacy: \$5 per prescription for 1 to 30 days; Mail order: Usually two times the plan pharmacy cost sharing for up to a 100-day supply	Not Covered	In accordance with formulary guidelines. Certain drugs may be covered at a different cost share.
	Preferred brand drugs	Plan pharmacy: \$20 per prescription for 1 to 30 days; Mail order: Usually two times the plan pharmacy cost sharing for up to a 100-day supply	Not Covered	In accordance with formulary guidelines. Certain drugs may be covered at a different cost share.
	Non-preferred brand drugs	Same as preferred brand drugs.	Not Covered	Same as preferred brand drugs when approved through exception process.
	Specialty drugs	Same as preferred brand drugs.	Not Covered	Same as preferred brand drugs when approved through exception process.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$15 per procedure	Not Covered	—————none—————
	Physician/surgeon fees	No Charge	Not Covered	—————none—————
If you need immediate medical attention	Emergency room services	\$50 per visit	\$50 per visit	—————none—————
	Emergency medical transportation	No Charge	No Charge	—————none—————
	Urgent care	\$15 per visit	\$15 per visit	Non-Plan providers covered when outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	—————none—————
	Physician/surgeon fee	No Charge	Not Covered	—————none—————

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Plan Provider	Non-Plan Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$15 per individual visit; \$7 per group visit	Not Covered	_____none_____
	Mental/Behavioral health inpatient services	No Charge	Not Covered	_____none_____
	Substance use disorder outpatient services	\$15 per individual visit; \$5 per group visit	Not Covered	_____none_____
	Substance use disorder inpatient services	No Charge	Not Covered	_____none_____
If you are pregnant	Prenatal and postnatal care	Prenatal care: No Charge; Postnatal care: No Charge	Prenatal care: Not covered; Postnatal care: Not covered	Prenatal: Cost sharing is for routine preventive care only; Postnatal: Cost sharing is for the first postnatal visit only.
	Delivery and all inpatient services	No Charge	Not Covered	_____none_____
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Up to 2 hours maximum per visit, up to 3 visits maximum per day, up to 100 visits maximum per calendar year.
	Rehabilitation services	Inpatient: No Charge; Outpatient: \$15 per day	Not Covered	_____none_____
	Habilitation services	\$15 per day	Not Covered	_____none_____
	Skilled nursing care	No Charge	Not Covered	Up to 100 days maximum per benefit period.
	Durable medical equipment	No Charge	Not Covered	Must be in accordance with formulary guidelines. Requires prior authorization.
	Hospice service	No Charge	Not Covered	Limited to diagnoses of a terminal illness with a life expectancy of twelve months or less.

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Plan Provider	Non-Plan Provider	
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	—————none—————
	Glasses	Not Covered	Not Covered	—————none—————
	Dental check-up	Not Covered	Not Covered	You may have other dental coverage not described here.

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 <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Chiropractic care • Cosmetic surgery • Dental care (Adult) 	<ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing 	<ul style="list-style-type: none"> • Routine foot care unless medically necessary • 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.)		
<ul style="list-style-type: none"> • Acupuncture (plan provider referred) • Bariatric surgery 	<ul style="list-style-type: none"> • Hearing aids • Infertility treatment 	<ul style="list-style-type: none"> • 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 1-800-278-3296. 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.

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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: Kaiser Permanente at 1-800-278-3296 or online at www.kp.org/memberservices.

If this coverage is subject to ERISA, you may contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, and the California Department of Insurance at 1-800-927-HELP (4357) or www.insurance.ca.gov.

If this coverage is not subject to ERISA, you may also contact the California Department of Insurance at 1-800-927-HELP (4357) or www.insurance.ca.gov.

Additionally, this consumer assistance program can help you file your appeal:

Department of Managed Health Care Help Center	1-888-466-2219
980 9th Street, Suite 500	www.healthhelp.ca.gov
Sacramento, CA 95814	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.**

* Due to Kaiser's system issues, the 2015 Kaiser SBC is not available yet. There were no changes to the plan except for the pharmacy out-of-pocket maximums.

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-788-0616 or TTY/TDD 1-800-777-1370

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-278-3296 or TTY/TDD 1-800-777-1370

CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 1-800-757-7585 or TTY/TDD 1-800-777-1370

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-800-278-3296 or TTY/TDD 1-800-777-1370

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 \$7,330
- Patient pays \$210

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	\$200
Total	\$210

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.

Questions: Call 1-800-278-3296 or 1-800-777-1370 (TTY), or visit us at www.kp.org.

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.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-800-278-3296 or 1-800-777-1370 (TTY) to request a copy.

* Due to Kaiser's system issues, the 2015 Kaiser SBC is not available yet. There were no changes to the plan except for the pharmacy out-of-pocket maximums.

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