Anthem BlueCross BlueShield ClearProtection Plus

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

Coverage Period: 01/01/2013 - 01/01/2014

Coverage For: Individual/Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.medicoverage.com or by calling 800-930-7956.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$3300** single / **$6600** family for In-Network Provider **$3300** single / **$6600** family for Non-Network Provider Does not apply to In-Network Preventive Care, Copayments and Prescription Drugs	You must pay all the costs up to the **deductible** amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the **deductible** starts over (usually, but not always, January 1st.) See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	Yes; **$7500** for Prescription Drug Deductible for tiers 2 and 4 only.	You must pay all the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes; In-Network Provider Single: **$6800**, Family: **$13600** Non-Network Provider Single: **$6800**, Family: **$13600**	The **out-of-pocket limit** is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Balance-Billed Charges, Copayments, Health Care This Plan Doesn't Cover, Premiums, Costs Related to Covered Prescription Drugs.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the insurer pays?	No. This policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 3 describes any limits on what the insurer will pay for specific covered services, such as office visits.

Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes. Call 800-930-7956 or www.medicoverage.com for a list of providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Plans use the terms in-network, preferred, or participating to refer to providers in their network.
Do I need a referral to see a specialist?	No, you do not need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 8. See your policy or plan document for additional information about excluded services.

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

Common Medical Event	Services You May Need	Your Cost If You Use a In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 copay for first 2 visits and then 0% coinsurance	0% coinsurance	Outpatient Professional and Diagnostic Services deductible must be satisfied before member cost-share applies.
	Specialist visit	$40 copay for first 2 visits and then 0% coinsurance	0% coinsurance	Outpatient Professional and Diagnostic Services deductible must be satisfied before member cost-share applies.
	Other practitioner office visit	Chiropractor Not covered Acupuncturist Not covered	Chiropractor Not covered Acupuncturist Not covered	————none————
	Preventive care/screening/ immunizations	No charge	$40 copay	Outpatient Professional and Diagnostic Services deductible must be satisfied before member cost-share applies. Non-Network: $40 copay with deductible waived coverage applies for nationally recommended preventive services.
If you have a test	Diagnostic test (x-ray, blood work)	Lab - Office 30% coinsurance X-Ray - Office 30% coinsurance	Lab - Office 50% coinsurance X-Ray - Office 50% coinsurance	Lab - Office Costs may vary by site of service. You should refer to your formal contract of coverage for details. X-Ray - Office Costs may vary by site of service. You should refer to your formal contract of coverage for details.

Common Medical Event	Services You May Need	Your Cost If You Use a In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	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 **prescription drug coverage** is available at www.anthem.com/pharmacyinformation/	Tier 1 – Generic Drugs	$15 copay/ prescription (retail only) and $45 copay/prescription (mail order only)	Not covered	Unless otherwise indicated, all retail sales have a 30 day limit. Mail Service has a 90 day limit.
	Tier 2 – Preferred/Formulary Drugs	$40 copay/ prescription (retail only) and $120 copay/prescription (mail order only)	Not covered	Additional deductible of $7500 applies. Unless otherwise indicated, all retail sales have a 30 day limit. Mail Service has a 90 day limit.
	Tier 3 – Typically Non-preferred/ non-Formulary Drugs	Not covered	Not covered	Additional deductible of $7500 applies. Unless otherwise indicated all retail sales have a 30 day limit. Mail Service has a 90 day limit. Specialty medications are limited to a 30 day supply regardless of whether they are retail or mail service. $2500 annual out-of-pocket limit per member In-Network (retail and mail order).

Common Medical Event	Services You May Need	Your Cost If You Use a In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Tier 4 – Typically Specialty Drugs	25% coinsurance (retail and mail order)	Not covered	Additional deductible of $7500 applies. If the member selects a brand drug when a generic equivalent is available the member is responsible for cost difference between the generic and brand equivalent, even if the physician indicates no substitutions. Member is responsible for any amount greater than the In-Network allowed amount. Unless otherwise indicated all retail sales have a 30 day limit. Mail Service has a 90 day limit. Specialty medications are limited to a 30 day supply regardless of whether they are retail or mail service. $2500 annual out-of-pocket limit per member In-Network (retail and mail order).
If you have outpatient Surgery	Facility Fee (e.g., ambulatory surgery center)	0% coinsurance	0% coinsurance	Outpatient Professional and Diagnostic Services deductible must be satisfied before member cost-share applies.
	Physician/Surgeon Fees	0% coinsurance	0% coinsurance	Outpatient Professional and Diagnostic Services deductible must be satisfied before member cost-share applies.
If you need immediate medical attention	Emergency Room Services	$100 copay and then 30% coinsurance	$100 copay and then 30% coinsurance	copay waived if admitted
	Emergency Medical Transportation	30% coinsurance	30% coinsurance	————none————
	Urgent Care	0% coinsurance	0% coinsurance	Outpatient Professional and Diagnostic Services deductible must be satisfied before member cost-share applies. 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)	30% coinsurance	50% coinsurance	————none————

Common Medical Event	Services You May Need	Your Cost If You Use a In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Physician/surgeon fee	30% coinsurance	50% coinsurance	————none————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit Not covered Mental/Behavioral Health Facility Visit - Facility Charges Not covered	Mental/Behavioral Health Office Visit Not covered Mental/Behavioral Health Facility Visit - Facility Charges Not covered	————none————
	Mental/Behavioral health inpatient services	Not covered	Not covered	————none————
	Substance use disorder outpatient services	Substance Abuse Office Visit Not covered Substance Abuse Facility Visit - Facility Charges Not covered	Substance Abuse Office Visit Not covered Substance Abuse Facility Visit - Facility Charges Not covered	————none————
	Substance use disorder inpatient services	Not covered	Not covered	————none————
If you are pregnant	Prenatal and postnatal care	0% coinsurance	0% coinsurance	Outpatient Professional and Diagnostic Services deductible must be satisfied before member cost-share applies. Your doctor's charges for delivery are part of prenatal and postnatal care.
	Delivery and all inpatient services	30% coinsurance	50% coinsurance	————none————
If you need help recovering or have other special health needs	Home Health Care	30% coinsurance	50% coinsurance	Coverage is limited to a total of 60 visits, In-Network Provider and Non-Network Provider combined per year.

Common Medical Event	Services You May Need	Your Cost If You Use a In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Rehabilitation Services	0% coinsurance	0% coinsurance	Coverage is limited to 24 visits per year for physical therapy and occupational therapy combined and 50 visits per year for speech therapy combined In-Network and Non-Network. Outpatient Professional and Diagnostic Services deductible must be satisfied before member cost-share applies. Children age 3-6 have a combined 20 visit limit for physical, occupational and speech therapy.
	Habilitation Services	0% coinsurance	0% coinsurance	Habilitation visits count towards your Rehabilitation limit.
	Skilled Nursing Care	30% coinsurance	50% coinsurance	Coverage is limited to a total of 30 days, In-Network Provider and Non-Network Provider combined per year.
	Durable medical equipment	30% coinsurance	50% coinsurance	Coverage is limited to $500 for wigs and $400 for footwear. Costs may vary by site of service. You should refer to your formal contract of coverage for details.
	Hospice service	30% coinsurance	50% coinsurance	Coverage is limited to a total of 91 days, In-Network Provider and Non-Network Provider combined per year up to 3 benefit period maximum. Limitations and cost shares may vary by site of service. You should refer to your formal contract of coverage for details.
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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Infertility treatment
- Long- term care
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide.
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care
- Weight loss programs
- Mental Health and Substance Abuse services

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.)

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-888-231-5046. You may also contact your state insurance department at:

Division of Insurance
ICARE Section
1560 Broadway, Suite 850
Denver, Colorado 80202
(303) 894-7490

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:

Division of Insurance
ICARE Section
1560 Broadway, Suite 850
Denver, Colorado 80202
(303) 894-7490

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíiłkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

About These Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $2,880
- **Patient pays:** $4,660

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Total Deductibles	$3,300
Co-pays	$20
Co-insurance	$1,190
Limits or exclusions	$150
Total	**$4,660**

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $1,530
- **Patient pays:** $3,870

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Total Deductibles	$3,300
Co-pays	$320
Co-insurance	$170
Limits or exclusions	$80
Total	**$3,870**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.medicoverage.com or by calling 800-930-7956..

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles, co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: www.medicoverage.com or by calling 800-930-7956.
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.cciio.cms.gov or call 1-888-231-5046 to request a copy.