

**Anthem Blue Cross**  
**Teamsters Misc. Trust Fund Plan T2-2/SD2-SD15-North**  
**Classic HMO 15/30/250 Admit**

**Coverage Period: 10/01/2014 - 09/30/2015**

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

**Coverage for: Individual/Family | Plan Type: HMO**



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at <http://www.anthem.com/ca> or by calling 1-855-333-5730.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	For In-Network Providers <b>\$0</b> Individual/ <b>\$0</b> Family For Out-of-Network Providers <b>\$0</b> Individual/ <b>\$0</b> Family	See the chart starting on page 2 for your costs for services this plan covers.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <b>deductibles</b> 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 <b>\$2,000</b> Individual/ <b>\$6,000</b> Family. For Out-of-Network Providers <b>\$0</b> Individual/ <b>\$0</b> Family	The <b>out-of-pocket limit</b> 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, Premiums, Balance-Billed Charges, Costs Related to Prescription Drugs Covered Under the Prescription Drug Plan, and Health Care this Plan Doesn't Cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
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 <a href="http://www.anthem.com/ca">http://www.anthem.com/ca</a> or call 1-855-333-5730 for a list of In-Network Providers.	If you use an in-network doctor or other health care <b>provider</b> , 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 <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
Do I need a referral to	Yes.	This plan will pay some or all of the costs to see a <b>specialist</b> for covered services but

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see a <u>specialist</u> ?		only if you have the plan's permission before you see the <u>specialist</u> .
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 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 <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	\$15 Copay/Visit	Not Covered	-----none-----
	Specialist visit	\$30 Copay/Visit	Not Covered	-----none-----
	Other practitioner office visit	<u>Chiropractor</u> \$30 Copay/Visit <u>Acupuncturist</u> \$15 Copay/Visit	<u>Chiropractor</u> Not Covered <u>Acupuncturist</u> Not Covered	-----none-----
	Preventive care/screening/immunization	No Cost Share	Not Covered	-----none-----

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If you have a test	Diagnostic test (x-ray, blood work)	<u>Lab – Office</u> No Cost Share <u>X-Ray – Office</u> No Cost Share	<u>Lab – Office</u> Not Covered <u>X-Ray – Office</u> 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.

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<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <b>prescription drug coverage</b> is available at <a href="https://www.anthem.com/ca/health-insurance/provider-directory/searchcriteria?branding=ABC&amp;provtype=Rx">https://www.anthem.com/ca/health-insurance/provider-directory/searchcriteria?branding=ABC&amp;provtype=Rx</a></p>	<p>Generic Drugs <i>(includes diabetic supplies &amp; self-injectable drugs)</i></p>	<p><b>\$13</b> Copay/ prescription (retail) <b>\$26</b> Copay/ prescription (home delivery)</p>	<p><b>\$13</b> Copay/ prescription plus <b>50%</b> of the remaining prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowed amount</p>	<p>Covers up to a 30 day supply for Retail pharmacy or a 90 day supply for Home Delivery. For Non-Participating Pharmacies, compound drugs &amp; certain specialty pharmacy drugs may require preauthorization or are not covered. 30-day supply; 60-day supply for Federally Classified Schedule II Attention Deficit Disorder drugs that require a triplicate prescription require double copay available only at a Retail Pharmacy.</p>
	<p>Brand Name Drugs <i>(includes self-injectable drugs)</i></p>	<p><b>\$35</b> Copay/ prescription (retail) <b>\$60</b> Copay/ prescription (home delivery)</p>	<p><b>\$35</b> Copay/ prescription plus <b>50%</b> of the remaining prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowed amount</p>	
	<p>Brand Name Drugs <i>(includes self-injectable drugs)</i></p>	<p><b>\$35</b> Copay/ prescription (retail) <b>\$60</b> Copay/ prescription (home delivery)</p>	<p><b>\$35</b> Copay/ prescription plus <b>50%</b> of the remaining prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowed amount</p>	

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	Specialty Drugs <i>(includes self-injectable drugs)</i>	<b>\$13</b> Copay/ prescription for Generic drugs <b>\$35</b> Copay/ prescription for Brand name drugs	<b>50%</b> of the remaining prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowed amount	Compound drugs & specialty pharmacy drugs are not covered.  30-day supply for Specialty Pharmacy.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	<b>\$100</b> Copay/Admit	Not Covered	-----none-----
	Physician/surgeon fees	No Cost Share	Not Covered	-----none-----
<b>If you need immediate medical attention</b>	Emergency room services	<b>\$100</b> 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.
	Emergency medical transportation	<b>\$50</b> Copay/Trip	Covered as In-Network	-----none-----
	Urgent care	<b>\$50</b> Copay/Visit	Covered as In-Network	Copay waived if admitted inpatient and outpatient ER. Non-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.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	<b>\$250</b> Copay/Admit	Not Covered	-----none-----
	Physician/surgeon fee	No Cost Share	Not Covered	-----none-----

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<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	<u>Mental/Behavioral Health Office Visit</u> \$15 Copay/Visit <u>Mental/Behavioral Health Facility Visit – Facility Charges</u> No Cost Share	<u>Mental/Behavioral Health Office Visit</u> Not Covered <u>Mental/Behavioral Health Facility Visit – Facility Charges</u> 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 abuse disorder outpatient services	<u>Substance Abuse Office Visit</u> \$15 Copay/Visit <u>Substance Abuse Facility Visit – Facility Charges</u> No Cost Share	<u>Substance Abuse Office Visit</u> Not Covered <u>Substance Abuse Facility Visit – Facility Charges</u> Not Covered	-----none-----
	Substance abuse disorder inpatient services	No Cost Share	Not Covered	This is for facility professional services only. Please refer to your hospital stay for facility fee.
<b>If you are pregnant</b>	Prenatal and postnatal care	No Cost Share	Not Covered	-----none-----
	Delivery and all inpatient services	\$250 Copay/Admit	Not Covered	-----none-----

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<b>If you need help recovering or have other special health needs</b>	Home health care	<b>\$15</b> Copay/Visit	Not Covered	Coverage is limited to 100 visits/benefit period (one visit by a home health aide equals four hours or less).
	Rehabilitation services	<b>\$30</b> Copay/Visit	Not Covered	-----none-----
	Habilitation services	<b>\$30</b> Copay/Visit	Not Covered	Services received in a hospital, other than emergency room services, or in any facility that is affiliated with a hospital. All rehabilitation and habilitation visits count toward your rehabilitation visit limit. Costs may vary by site of service. Please refer to your formal contract.
	Skilled nursing care	<b>\$250</b> Copay/Admit	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.
<b>If your child needs dental or eye care</b>	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)
- Infertility treatment
- 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 Aid Rider (**No Cost Share**)

**Your Rights to Continue Coverage:**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-333-5730. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://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](http://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:

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](http://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](mailto: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.**

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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 ei dooda'i, shikaa adoolwol iiniginigo t'aa diné k'éjugo, t'aa shoodi ba na'alnihi ya sidahi bich'i naabidiilkiid. Ei doo biigha daago ni ba'nija'go ho'aalagii bich'i hodiilni. Hai'daqa iini'taago eiya, t'aa shoodi diné ya atah halne'igii ni beesh bee hane'i wolta' bi'ki si'niiligi bi'kehgo 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.*—————

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## 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:** \$7,120
- **Patient pays:** \$420

#### 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
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$0
Copays	\$270
Coinsurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$420</b>

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

- **Amount owed to providers:** \$5,400
- **Plan pays:** \$4,650
- **Patient pays:** \$750

#### 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
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$0
Copays	\$670
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$750</b>

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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.

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