

# Anthem Blue Cross Life and Health Insurance Company

## CSAC EIA, City of Clovis: Custom Lumenos HSA 3000/ 0/50 (LHSA500)

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

Coverage Period: 01/01/2017 – 12/31/2017

Coverage for: Individual + Family | Plan Type: CDHP



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.anthem.com/ca/EIAHealth](http://www.anthem.com/ca/EIAHealth) or by calling (855) 826-0710.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	<b>\$3,000</b> single / <b>\$6,000</b> family for In-Network Providers. Does not apply to Preventive care. <b>\$3,000</b> single / <b>\$6,000</b> family for Out-of-Network Providers. In-Network Providers and Non-Network Providers deductibles are combined. Satisfying one helps satisfy the other.	You must pay all costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> 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 <b>deductible</b> .
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 3 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes; <b>\$3,000</b> single / <b>\$6,000</b> family for In-Network Providers. <b>\$5,000</b> single / <b>\$10,000</b> family for Out-of-Network Providers. In-Network Providers and Non-Network Providers Out of Pocket are separate and do not count towards each other.	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> ?	Premiums, Balance-Billed charges, 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> .

**Questions:** Call (855) 826-0710 or visit us at [www.anthem.com/ca/EIAHealth](http://www.anthem.com/ca/EIAHealth)

CA/L/A/CSACEIACYCLSCULHSA3000050500-CDHP/NA/NA/01-17

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](http://www.cciio.cms.gov) or call (855) 826-0710 to request a copy.

Important Questions	Answers	Why this Matters:
<b>Is there an overall annual limit on what the plan pays?</b>	No.	The chart starting on page 3 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
<b>Does this plan use a <u>network of providers</u>?</b>	Yes, Prudent Buyer PPO. For a list of In-Network providers, see <a href="http://www.anthem.com/ca/EIAHealth">www.anthem.com/ca/EIAHealth</a> or call (855) 826-0710.	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 3 for how this plan pays different kinds of <b>providers</b> .
<b>Do I need a referral to see a <u>specialist</u>?</b>	No; you do not need a referral to see a specialist.	You can see the <b>specialist</b> you choose without permission from this plan.
<b>Are there services this plan doesn't cover?</b>	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 <b>excluded services</b> .



- **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 Non-Network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	50% coinsurance	-----none-----
	Specialist visit	0% coinsurance	50% coinsurance	-----none-----
	Other practitioner office visit	Chiropractor 0% coinsurance Acupuncture 0% coinsurance	Chiropractor 50% coinsurance Acupuncture 50% coinsurance	Chiropractor Coverage is limited to 24 visits combined per benefit period including physical therapy, physical medicine and occupational therapy. Acupuncture Coverage is limited to 12 visits combined per benefit period.
	Preventive care/screening /immunization	No cost share	50% coinsurance	-----none-----
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office 0% coinsurance X-Ray – Office 0% coinsurance	Lab – Office 50% coinsurance X-Ray – Office 50% coinsurance	Lab – Office -----none----- X-Ray – Office -----none-----

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Non-Network Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	0% coinsurance	50% coinsurance	Costs may vary by site of service.
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.anthem.com/ca/pharmacyinformation/">http://www.anthem.com/ca/pharmacyinformation/</a>	Tier 1 - Typically Generic	\$0 copay per prescription (retail only) and \$0 copay per prescription (home delivery only)	50% coinsurance (retail only)	Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program)
	Tier 2 - Typically Preferred / Brand	\$0 copay per prescription (retail only) and \$0 copay per prescription (home delivery only)	50% coinsurance (retail only)	Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program)
	Tier 3 - Typically Non-Preferred / Specialty Drugs	\$0 copay per prescription (retail only) and \$0 copay per prescription (home delivery only)	50% coinsurance (retail only)	Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program)
	Tier 4 - Typically Specialty Drugs	\$0 copay per prescription (retail only)	Not covered	Covers up to a 30 day supply (retail pharmacy) Classified specialty drugs must be obtained through Specialty Pharmacy Program and subject to the program terms.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	50% coinsurance	-----none-----
	Physician/surgeon fees	0% coinsurance	50% coinsurance	-----none-----
<b>If you need immediate medical attention</b>	Emergency room services	0% coinsurance	Covered as In-Network	-----none-----

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Non-Network Provider	Limitations & Exceptions
	Emergency medical transportation	0% coinsurance	Covered as In-Network	-----none-----
	Urgent care	0% coinsurance	50% coinsurance	-----none-----
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	0% coinsurance	50% coinsurance	-----none-----
	Physician/surgeon fee	0% coinsurance	50% coinsurance	-----none-----
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit 0% coinsurance for non-preventive visit Mental/Behavioral Health Other Outpatient Items and Services 0% coinsurance for non-preventive visit	Mental/Behavioral Health Office Visit 50% coinsurance Mental/Behavioral Health Other Outpatient Items and Services 50% coinsurance	Mental/Behavioral Health Office Visit -----none----- Mental/Behavioral Health Other Outpatient Items and Services -----none-----
	Mental/Behavioral health inpatient services	0% coinsurance	50% coinsurance	This is for facility professional services only. Refer to hospital stay for facility fees.
	Substance use disorder outpatient services	Substance Use Office Visit 0% coinsurance for non-preventive visit Substance Use Facility Visit - Facility Charges 0% coinsurance for non-	Substance Use Office Visit 50% coinsurance Substance Use Facility Visit - Facility Charges 50% coinsurance	Substance Use Office Visit -----none----- Substance Use Facility Visit - Facility Charges -----none-----

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Non-Network Provider	Limitations & Exceptions
		preventive visit		
	Substance use disorder inpatient services	0% coinsurance	50% coinsurance	This is for facility professional services only. Refer to hospital stay for facility fees.
<b>If you are pregnant</b>	Prenatal and postnatal care	0% coinsurance	50% coinsurance	In-Network preventive prenatal and postnatal services are covered at 100%.
	Delivery and all inpatient services	0% coinsurance	50% coinsurance	-----none-----
<b>If you need help recovering or have other special health needs</b>	Home health care	0% coinsurance	50% coinsurance	Coverage for In-Network Providers and Non-Network Providers combined is limited to 100 visits per benefit period.
	Rehabilitation services	0% coinsurance	50% coinsurance	Coverage for In-Network Providers and Non-Network Providers combined is limited to 24 visits per benefit period for physical therapy, physical medicine and occupational therapy including chiropractic services.
	Habilitation services	0% coinsurance	50% coinsurance	Habilitation visits count towards your rehabilitation limit.

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Non-Network Provider	Limitations & Exceptions
	Skilled nursing care	0% coinsurance	50% coinsurance	Coverage for In-Network Providers and Non-Network Providers combined is limited to 100 days limit per benefit period.
	Durable medical equipment	0% coinsurance	50% coinsurance	-----none-----
	Hospice service	0% coinsurance	50% coinsurance	-----none-----
<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-----

## 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.
- 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 only.
- 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](http://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 (855) 826-0710. 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).

## 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:

ATTN: Grievances and Appeals  
P.O. Box 4310  
Woodland Hills, CA 91365-4310

Department of Labor, Employee  
Benefits Security Administration  
(866) 444-EBSA (3272)  
[www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

California Department of Insurance  
Consumer Communications Bureau  
300 South Spring Street, South  
Tower  
Los Angeles, CA 90013  
1-800-927-HELP (4357)  
1-213-897-8921  
1-800-482-4TDD (4633)  
<http://www.insurance.ca.gov/>

## Language Access Services:

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 adoolwol íínízinigo t'áá diné k'éjígoo, t'áá shoodí ba na'alníhí ya sidáhí bich'í naabídíílkíid. Eí doo biigha daago ni ba'nija'go ho'aalagí bich'í hodiilní. Hai'daa íini'taago eíya, t'áá shoodí diné ya atáh halne'ígú ní béesh bee hane'í wólta' bi'ki si'niilígú bi'kéhgo bich'í 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.

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.

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*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 \$4,390
- Patient pays \$3,150

#### 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	\$3,000
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$3,150</b>

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

#### Patient pays:

Deductibles	\$3,000
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$3,080</b>

# 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 (855) 826-0710 or visit us at [www.anthem.com/ca/EIAHealth](http://www.anthem.com/ca/EIAHealth)

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## Language Access Services:

(TTY/TDD: 711)

**Albanian (Shqip):** Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (855) 826-0710

**Amharic (አማርኛ):-** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 826-0710 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (855) 826-0710.

**Armenian (հայերեն).** Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (855) 826-0710:

**Bassa (Bàsɔ́ Wùdù):** M̄ dyi dyi-diè-dɛ̀ bɛ̀ bédé b́á céè-dɛ̀ nià ke dyí ní, ɔ̀ m̀ò ni dyí-bédɛ̀in-dɛ̀ bɛ̀ é̀ m̀ ké gbo-kpá-kpá kè b̄́ kp̄́ dɛ̀ m̀ bídǐ-wùdù̀ùn b́ó pídyi. B́é m̀ ké wuɖu-zìin-nyò d̀ò gbo wùdù̀ ke, d́á (855) 826-0710.

**Bengali (বাংলা):** যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (855) 826-0710 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (855) 826-0710 သို့ ခေါ်ဆိုပါ။

**Chinese (中文) :** 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (855) 826-0710。

**Dinka (Dinka):** Na nɔŋ thiëc në ke de yä thorë, ke yin nɔŋ loŋ bë yi kuony ku wër alëu bë gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kør yin ba jam wënë ran ye thok geryic, ke yin cəl (855) 826-0710.

**Dutch (Nederlands):** Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (855) 826-0710.

Farsi (فارسی): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (855) 826-0710 تماس بگیرید.

**French (Français) :** Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (855) 826-0710.

## Language Access Services:

**German (Deutsch):** Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (855) 826-0710.

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**Haitian Creole (Kreyòl Ayisyen):** Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (855) 826-0710.

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## Language Access Services:

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**Lao (ພາສາລາວ):** ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.  
ເພື່ອໂອ້ນລັບກ່ຽວກັບລາຍລະອຽດ, ໃຫ້ໃບທາ (855) 826-0710.

**Navajo (Diné):** Dii naaltsoos biká'ígíí lahgo bina'idiilkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjì bee nił hodoonih t'áadoo báąh ilinígóó.  
Ata' halne'ígíí la' bich'i' hadeesdzih nínízingo kojì' hodiilnih (855) 826-0710.

**Nepali (नेपाली):** यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ।  
दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (855) 826-0710

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## Language Access Services:

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