Central Unified School District: Gold Plan

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

Coverage Period: 12/01/2015-11/30/2016
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 by calling **1-559-274-4700 ext 63103** or view on the intranet at **www.centralunified.org**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$200** / person Maximum: 3 times individual / family Does not apply to in-network services, ambulatory surgery centers, birthing centers, out-patient diagnostic testing, Hearing Screenings.	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 out–of–pocket limit on my expenses?	Medical Benefits: **$2,250** / person **$4,500** / family Pharmacy Benefits: **$4,350** / person **$8,700** / 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 out–of–pocket limit?	Premiums, balance-billed charges, non-covered expenses, Rx Copays, expenses in excess of non-Network UCR, non-Essential Health Benefits, and penalties for non-compliance with Utilization Management.	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 *specific* coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. See **www.anthem.com/ca** or call **1-800-999-3643** 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 cost 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?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.

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If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at **http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf** or call **1-559-274-4700 ext 63103** to request a copy.

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**.

- **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 **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** 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	$25/visit	50% coinsurance	Exam only
	Specialist visit	$25/visit	50% coinsurance	Exam only
	Other practitioner office visit	Chiropractic: $15/visit Acupuncture Services: 15% coinsurance	Chiropractor: Not covered Acupuncture Services: 50% coinsurance	Chiropractic Services: Limited to 30 visits / calendar year. Network is Chirometrics, Inc. Acupuncture is covered for pain management only. Acupuncture must be performed by a Board Certified Acupuncturist.
	Preventive care/screening/immunization	No charge	50% coinsurance	Recommended frequency based on nationally mandated guidelines.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	50% coinsurance	Prior authorization required for any single procedure exceeding $350 or benefits reduced by 50%.
	Imaging (CT/PET scans, MRIs)	No charge	50% coinsurance	Prior authorization required for any single procedure exceeding $350 or benefits reduced by 50%.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com/wps/portal	Generic Drug drugs	$5/prescription (retail); $10/prescription (mail order)	Not covered	Retail: 34-day supply Mail order drugs are available in up to a 90-day supply with 1 Copay. The Plan requires that maintenance medications be obtained only through the Caremark mail order option or the Maintenance Choice Option at CVS Pharmacies after 2 fills at a retail pharmacy. If you are taking a brand-name drug, have not tried a generic form in the last 24 months and your doctor has not received prior approval for the brand-name drug, then your drug may not be covered by this Plan.
	Preferred Brand-Name Drug drugs	$30/prescription (retail); $60/prescription (mail order)	Not covered	
	Non-Preferred Brand Name Drug drugs	$50/prescription (retail); $70/prescription (mail order)	Not covered	
	Non-Formulary Drug	$50/prescription (retail); $100/prescription (mail order)	Not covered	
	Specialty drugs	$100/prescription (retail/mail order)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	50% coinsurance	Requires Prior Authorization or additional $250 copay/occurrence
	Physician/surgeon fees	No charge	50% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	$100 copay, then 15% coinsurance	$100 copay, then 15% coinsurance	Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	——————none——————

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
	Urgent care	Hospital Based Facility: $100 copay, then 15% coinsurance Freestanding Clinic: $25 copay	Hospital Based Facility: $100 copay, then 50% coinsurance Freestanding Clinic: 50% coinsurance	Copay waived if admitted.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	50% coinsurance	Requires prior authorization or additional $250 copay/admission
	Physician/surgeon fee	15% coinsurance	50% coinsurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs **Note: Claims sent to the Holman Group 1-800-321-2843**	Mental/Behavioral health outpatient services	$25/visit	50% coinsurance	Exam only
	Mental/Behavioral health inpatient services	15% coinsurance	50% coinsurance	Requires prior authorization or additional $250 copay/admission
	Substance use disorder outpatient services	$25/visit	50% coinsurance	Exam only
	Substance use disorder inpatient services	15% coinsurance	50% coinsurance	Requires prior authorization or additional $250 copay/admission
If you are pregnant	Prenatal and postnatal care	$25 copay/visit	50% coinsurance	Exam only. Certain services at no charge under Preventive Care benefit.
	Delivery and all inpatient services	15% coinsurance	50% coinsurance	No prior authorization is required for 48 hours following a vaginal delivery and 96 hours following a cesarean delivery. If exceeds those hours, then a prior authorization is required for mother and newborn or no further benefit.

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	No charge	50% coinsurance	Limited to 100 visits / calendar year. Visit equals 4 hours or less.
	Rehabilitation services	$25/visit	50% coinsurance	Proof of Medical Necessity required following 30 days of therapy without surgery and following 90 days of therapy with surgery
	Habilitation services	$25/visit	50% coinsurance	
	Skilled nursing care	First 30 days: 20% coinsurance. Next 30 days: 50% coinsurance	First 30 days: 20% coinsurance. Next 30 days: 50% coinsurance	Limited to 60 days / calendar year
	Durable medical equipment	15% coinsurance	50% coinsurance	Requires Prior Authorization for DME rentals and DME purchases over $500 or no additional benefit.
	Hospice service	20% coinsurance	20% coinsurance	Limted to $10,000 / lifetime
If your child needs dental or eye care	Eye exam	Not covered		Not covered
	Glasses	Not covered		Not covered
	Dental check-up	1st year: 30% coinsurance 2nd year: 20% coinsurance 3rd year: 10% coinsurance 4th year: No charge	1st year: 30% coinsurance 2nd year: 20% coinsurance 3rd year: 10% coinsurance 4th year: No charge	Maximum $1,250 / calendar year

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.)

- Bariatric surgery
- Cosmetic surgery
- Glasses
- Infertility treatment
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care
- Routine foot care
- Weight loss programs

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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 (pain management only)
- Chiropractic care
- Hearing aids ($1,000 in any 5-year period)
- Routine dental care

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 **1-866-566-7655**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov."

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: the plan at Advantek Benefit Administrators, 1180 E. Shaw, Suite 225, Fresno, CA 93710, **1-866-566-7655**. Please advise where the group would like these phone calls. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **559-274-4700 ext 63103**.

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 $6,230**
- **Patient pays $1,310**

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	$200
Copays	$10
Coinsurance	$950
Limits or exclusions	$150
Total	**$1,310**

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

- **Amount owed to providers: $5,400**
- **Plan pays $4,510**
- **Patient pays $890**

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	$200
Copays	$450
Coinsurance	$160
Limits or exclusions	$80
Total	**$890**

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 expense