

Lake County Board of Commissioners: PPO

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

Coverage Period: 01/01/2013 – 12/31/2013

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.anthem.com or by calling 1-855-239-9248

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	For in-network providers \$500 individual / \$1,000 family Does not apply to in-network preventive care. For out-of-network providers \$1,000 individual / \$2,000 family \$150 copay Lake Hospital-Deductible does not apply.	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> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> 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 \$2,500 individual / \$5,000 family For out-of-network providers \$5,000 individual / \$10,000 family	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.
What is not included in the <u>out-of-pocket limit</u> ?	Flat dollar copayments, premiums, balance-billed charges, health care this plan doesn't cover, and non-network human organ and tissue transplants.	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. For a list of <u>preferred providers</u> , see www.anthem.com or call 1-855-239-9248	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> .

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Do I need a referral to see a <u>specialist</u> ?	No.	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 5. 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</u> office or clinic	Primary care visit to treat an injury or illness	\$20/visit	40% coinsurance	—————none—————
	Specialist visit	\$40/visit	40% coinsurance	—————none—————
	Other practitioner office visit	\$40/visit	40% coinsurance	Combined network & out-of-network limits: Physical therapy – 20 visits Occupational therapy – 20 visits Manipulation therapy – 20 visits Speech therapy – 20 visits
	Preventive care/screening/immunization	No charge	40% coinsurance	—————none—————
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	—————none—————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	—————none—————

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If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.caremark.com	Generic drug copay	\$8 retail/\$16 mail	Not Covered	Retail 31 day supply Mail order 90 day supply Mandatory mail order on all maintenance medications
	Preferred brand drug copay	\$25 retail/\$50 mail	Not Covered	
	Non-preferred brand drug copay	\$45 retail/\$90 mail	Not Covered	
	Specialty drugs	10% coinsurance to a max of \$1500 annually	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	—————none—————
	Physician/surgeon fees	20% coinsurance	40% coinsurance	—————none—————
If you need immediate medical attention	Emergency room services	\$100/visit	\$100/visit	Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	40% coinsurance	—————none—————
	Urgent care	\$50/visit	40% coinsurance	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance; \$150 copay at Lake Hospital	40% coinsurance	\$150 copay at Lake Hospital only, deductible does not apply. All other facilities, network or out-of-network, are covered subject to deductible and coinsurance.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	—————none—————

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If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$20/visit	40% coinsurance	Inpatient: \$150 copay at Lake Hospital only, deductible does not apply. All other facilities, network or out-of-network, are covered subject to deductible and coinsurance.
	Mental/Behavioral health inpatient services	20% coinsurance; \$150 copay at Lake Hospital	40% coinsurance	
	Substance use disorder outpatient services	\$20/visit	40% coinsurance	Outpatient: Network copay applies to physician home/office visit only. All other network outpatient services covered at 20% coinsurance.
	Substance use disorder inpatient services	20% coinsurance; \$150 copay at Lake Hospital	40% coinsurance	
If you are pregnant	Prenatal and postnatal care	\$20/visit	40% coinsurance	Network copay applies to physician home/office visit only. All other network outpatient services covered at 20% coinsurance.
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	—————none—————
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	60 days combined network & out-of-network limit.
	Rehabilitation services	\$20 /visit	40% coinsurance	Combined network & out-of-network limits: Physical therapy – 20 visits Occupational therapy – 20 visits Manipulation therapy – 20 visits Speech therapy – 20 visits All other network outpatient services covered at 20% coinsurance.
	Habilitation services	\$20 /visit	40% coinsurance	All rehabilitation and habilitation visits count toward your rehabilitation visit limit.
	Skilled nursing care	20% coinsurance	40% coinsurance	60 days combined network & out-of-network limit.

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	Durable medical equipment	20% coinsurance	20% coinsurance	Includes medical supplies. Diabetic supplies only covered under the Rx vendor. TMJ appliances are not covered.
	Hospice service	20% coinsurance	40% coinsurance	180 days per lifetime, combined network & out-of-network
If your child needs dental or eye care	Eye exam	\$40 /visit	40% coinsurance	Preventive care services include routine vision screening.
	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
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Routine eye care (Adult)
- Private-duty nursing
- Routine foot care
- 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.)

- Chiropractic care
- Coverage provided outside the United States. See www.BCBS.com/bluecardworldwide
- Non-emergency care when traveling outside the U.S.

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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 1-855-239-9248. 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:

Anthem Grievance and Appeals
PO Box 105568
Atlanta, GA 30348

Ohio Department of Insurance 1-800-686-1526

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 adootwoł iin'izinigo t'aa diné k'éjügo, t'aa shoodí ba na'alnihi ya sidáhi bich'i naabidílkiiid. Eí doo biigha daago ni ba'nija'go ho'aalagii bich'i hodiilni. Hai'daa iini'taago eiya, t'aa shoodí diné ya atáh halne'ígii ní béesh bee hane'i wólta' bi'ki si'niilígii bi'kéhgo bich'i hodiilni.

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

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Coverage Examples

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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 \$5,840
- Patient pays \$1,700

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	\$20
Coinsurance	\$1,010
Limits or exclusions	\$170
Total	\$1,700

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

- Amount owed to providers: \$5,400
- Plan pays \$1,580
- Patient pays \$3,820

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	\$170
Coinsurance	\$220
Limits or exclusions	\$2,930
Total	\$3,820

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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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