



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 <https://www.blueshieldca.com/calpers> or by calling 800-334-5847.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$0	See the chart starting on page 3 for your costs for services this <u>plan</u> covers.
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 3 for other costs for services this <u>plan</u> covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. Individual \$1,500 / Family \$3,000	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 <u>plan</u> for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Access+ <u>Specialist</u> visits, mental health/substance abuse, infertility and outpatient <u>prescription drugs</u> , <u>premiums</u> , and health care this <u>plan</u> doesn't cover.	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 <u>plan</u> pays?	No.	The chart starting on page 3 describes any limits on what the <u>plan</u> will pay for specific covered services, such as office visits.
Does this <u>plan</u> use a <u>network</u> of <u>providers</u> ?	Yes. For a list of <u>preferred providers</u> , see https://www.blueshieldca.com/calpers or call 800-334-5847.	If you use an <u>in-network</u> doctor or other health care <u>provider</u> , this <u>plan</u> will pay some or all of the costs of covered services. Be aware, your <u>in-network</u> doctor or hospital may use an <u>out-of-network provider</u> for some services. Plans use the term <u>in-network</u> , preferred, or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 3 for how this <u>plan</u> pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	Yes. A referral is needed for Podiatry and Physical Therapy services. You may arrange an office visit with a <u>Plan specialist</u> in the same medical group or IPA as your Personal	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have the <u>plan</u> 's permission before you see the <u>specialist</u> .

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Blue Shield of California: CalPERS NetValue HMO

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Coverage for: Family | Plan Type: HMO

	Physician without a referral from your Personal Physician. Access+ <u>Specialist</u> office visits are available only to Members whose Personal Physicians belong to a medical group or IPA that participates as an Access+ <u>Provider</u> .	
Are there services this <u>plan</u> doesn't cover?	Yes.	Some of the services this <u>plan</u> doesn't cover are listed on page 5. See your policy or <u>plan</u> document for additional information about <u>excluded services</u> .

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- **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 **preferred providers** by charging you lower **deductibles**, **co-payments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15/visit	Not covered	_____none_____
	Specialist visit	\$15/visit with a referral or \$30/visit with self-referral	Not covered	Self referral to a participating specialist in the same medical group or IPA.
	Other practitioner office visit	Not covered	Not covered	_____none_____
	Preventive care/screening/immunization	No charge	Not covered	_____none_____
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	_____none_____
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	_____none_____
If you need drugs to treat your illness or condition	Generic drugs	\$5/prescription	Not covered	_____none_____
	Preferred brand drugs	\$20/prescription	Not covered	_____none_____
	Non-preferred brand drugs	\$50/prescription	Not covered	_____none_____
	Specialty drugs	\$30/prescription	Not covered	_____none_____
More information about prescription drug coverage is available at www.blueshieldca.com/calpers .				

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If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	This excludes endoscopy (including colonoscopy), spinal injection and cataract surgery, which will incur a \$250 co-pay unless performed at an ASC. This also excludes knee and hip surgery, which requires prior authorization and must be performed at a preferred knee/hip replacement center to be covered at 100%.
	Physician/surgeon fees	No charge	Not covered	_____none_____
If you need immediate medical attention	Emergency room services	\$50/visit (waived if admitted)	\$50/visit (waived if admitted)	_____none_____
	Emergency medical transportation	No charge	No charge	_____none_____
	Urgent care	\$15/visit	\$15/visit	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	_____none_____
	Physician/surgeon fee	No charge	Not covered	_____none_____
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$15/visit	Not covered	_____none_____
	Mental/Behavioral health inpatient services	No charge	Not covered	_____none_____
	Substance use disorder outpatient services	\$15/visit	Not covered	_____none_____
	Substance use disorder inpatient services	No charge	Not covered	_____none_____
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	_____none_____
	Delivery and all inpatient services	No charge	Not covered	_____none_____
If you need help	Home health care	No charge	Not covered	_____none_____

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	Rehabilitation services	No charge	Not covered	_____none_____
	Habilitation services	No charge	Not covered	_____none_____
	Skilled nursing care	No charge	Not covered	Coverage is limited to 100 days/calendar year.
	Durable medical equipment	No charge	Not covered	_____none_____
	Hospice service	No charge	Not covered	_____none_____
If your child needs dental or eye care	Eye exam	No charge	Not covered	No limit on number of visits for under 18 years old.
	Glasses	Not covered	Not covered	Not covered except (if) for necessary after cataract surgery.
	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
- Behavior Problems
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Infertility Reversal
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Over-the-Counter Medications
- Personal Comfort Items
- Routine foot care
- Services by Unlicensed **Providers**, except as otherwise specifically listed.
- Services that are not medically necessary.
- Sex Transformations
- Spinal Manipulation
- Unauthorized Non-**Emergency Services**
- Unapproved Drugs/Medicines
- 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.)

- Bariatric surgery
- Hearing aids
- Infertility treatment
- Private-duty nursing
- Routine eye care (Adult)

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 800-334-5847. 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: Blue Shield CalPERS Member Services at 800-334-5847 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the California Department of Managed Health Care at (888) 466-2219 or www.dmhca.ca.gov.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al (866) 346-7198.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (866) 346-7198.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 (866) 346-7198.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (866) 346-7198.

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 \$7,380
- Patient pays \$160

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	\$0
Copays	\$10
Co-insurance	\$0
Limits or exclusions	\$150
Total	\$160

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

- Amount owed to providers: \$5,400
- Plan pays \$4,970
- Patient pays \$430

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	\$0
Copays	\$350
Co-insurance	\$0
Limits or exclusions	\$80
Total	\$430

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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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