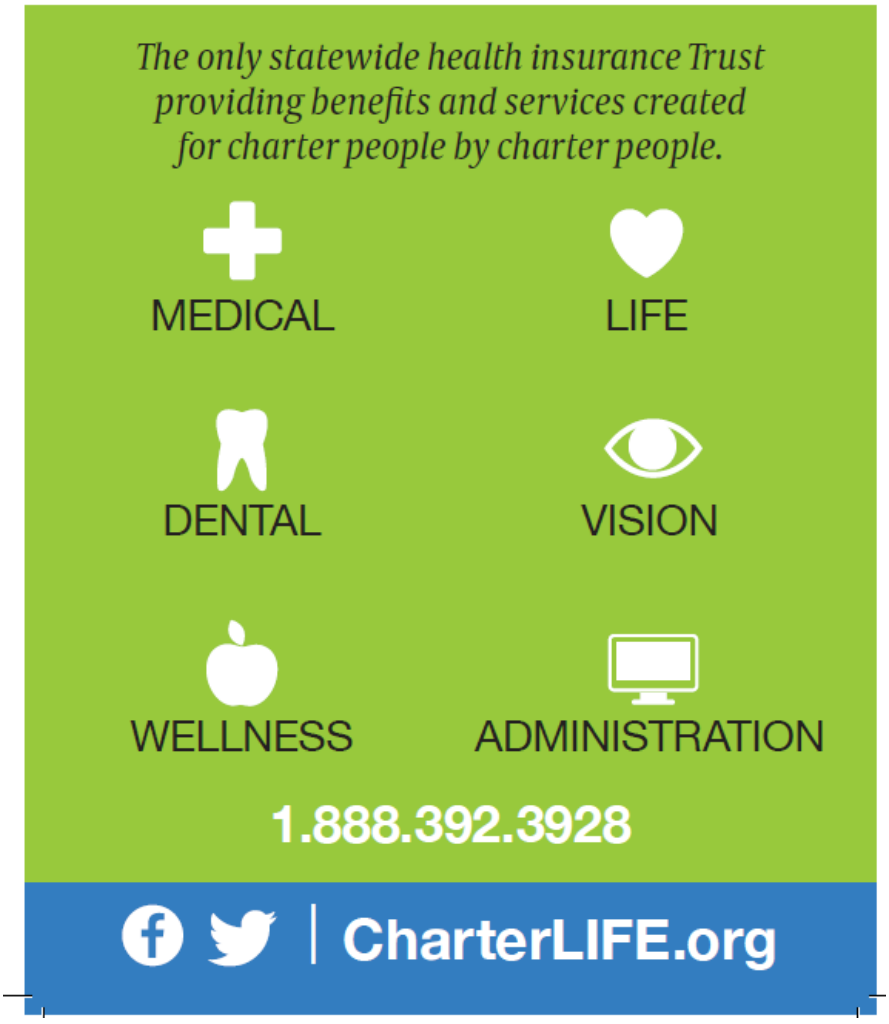
Da Vinci Schools



CharterLIFE Benefit Information Guide
(C-BIG)

SC 2022

CONTENTS

INTRODUCTION

WELCOME TO CharterLIFE!

We would like to extend a warm welcome, from the CharterLIFE team to you and yours! This CharterLIFE Benefit Information Guide (C-BIG) is created just for you.

As a valued employee of Da Vinci Schools we strive to provide you with timely and thorough member service from start to finish.

Please take the time to read through this guide so that you have a clear understanding of the benefits and services available to you as a CharterLIFE member.

You will find a helpful Contact List on page three, as well as a My health Benefits user reference guide, and much, much more! So…Let's get started!

CONTACT LIST

CharterLIFE™
Believe Build Benefit

Medical Anthem Blue Cross	Phone	Website
Member Services Eligibility, Claims, Provider Check, etc.	800-227-3670 (EPO/PPO)	www.anthem.com/ca
Optum Rx	844-568-2145	www.optumrx.com

Medical Kaiser Permanente	Phone	Website
Member Services Eligibility, Claims, Appointment, etc.	800-464-4000	kp.kaiserpermanente.org

Dental Delta Dental	Phone	Website
Member Services	800-422-4234 (HMO) 800-765-6003 (PPO)	www.deltadentalins.com
Billing and Enrollment	800-632-8555	CharterLIFE@brmsonline.com

Vision VSP	Phone	Website
Member Services, Eligibility, Claims, etc.	800-877-7195	www.vsp.com

Life/AD&D/Supplemental Life EAP/Travel Assistance - Unum	Phone	Website
Customer Services	800-421-0344	www.unum.com
Claim Address	The Benefits Center P.O. Box 100158 Columbia, SC 29202-3158 1-800-445-0402	

CharterLIFE Direct	Phone	Website/Email
CharterLIFE Direct	888-392-3928	Info@CharterLIFE.org

CharterLIFE Member Services (BRMS)	Phone	Website/Email
CharterLIFE Member Services (BRMS)	866-755-6651	CharterLIFE@brmsonline.com

School HR Representative	Phone	Website/Email
Jennifer Hawn	310-725-5800	Jhawn@davincischools.org

CharterLIFE Account Manager	Phone	Website/Email
Merica Mojica	323-310-0834	Helpdesk@Dickerson-group.com

Who is Eligible?

Full-time, regular employees who work at least 30 hours per week are considered benefit eligible. (subject to Da Vinci Schools eligibility guidelines).

You may also enroll your eligible dependent(s) in the plan(s). Your eligible dependents include:
• Your legal spouse
• Your registered domestic partner defined as same sex partners, who are both at least 18 yrs of age and opposite sex partners when one or both partners are over the age of 62.
• Your dependent children/step-children or children of your domestic partner whom you support up to age 26 (unless they can be enrolled in another group plan).

When You Can Enroll:

The plan year for CharterLIFE begins January 1st and ends December 31st.
• If you are a new hire, you should enroll within 30 days from your date of hire for your benefits to be effective the 1st of the month following your charter schools applicable waiting period.
• If you are an existing employee, you can enroll/make changes during the open enrollment period.
• If you are an existing employee who experiences a qualifying event, you can enroll/make changes at the time of the event as long as you notify Human Resources within 30 days (60 days for losing or gaining eligibility for Medicaid or state children's health plan).

How To Enroll:

Your enrollment will be processed on Paycom. For help in navigating the system, you can reference the Paycom Show-Me-How guide to enroll in benefits on the following pages, contact your HR representative listed in the Contacts on page three of this guide, email CharterLIFE member services at charterLIFE@brmsonline.com, or call 1.866.755.6651 before the effective date of coverage.

Your Special Enrollment Rights

Your enrollment in the medical, dental, and vision or declination of coverage when you are first eligible will remain in place unless you have a qualifying life event (or until the next annual open enrollment if applicable).

Examples of Qualifying Events:

•Marriage

• Divorce

• Legal separation

• Death of a dependent

• Birth or adoption of a child

• Change in your/your spouse's/domestic partner's employment status

• Loss of coverage under Medicaid or state child health plan

• Gaining eligibility for coverage under Medicaid or a state child health plan

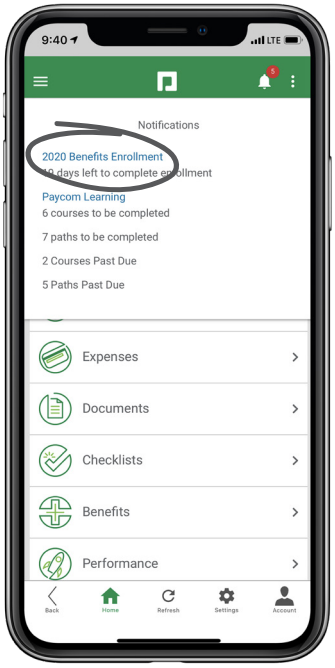
SHOW ME HOW

to Enroll in Benefits

Benefits

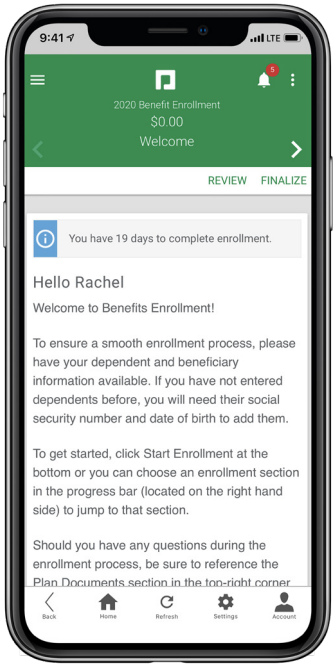
STEP 1

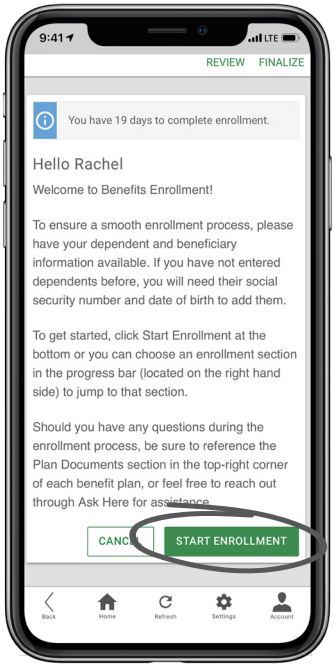
Log into the Paycom app. From the Notification Center or from the Benefits section, click the current year's Benefits Enrollment.



STEP 2

Review initial instructions and click "Start Enrollment." Then, enter your personal information and any dependents or beneficiaries.





EMPLOYEES

Visit the Help Menu for the most up-to-date version of this guide.

paycom

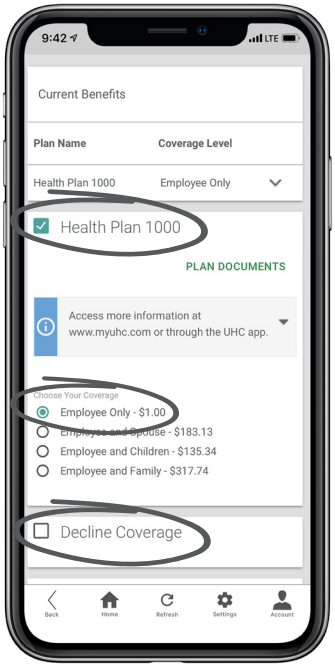
SHOW ME HOW

to Enroll in Benefits

Benefits

STEP 3

After determining which plan will work for you, choose your coverage level, then select either to enroll or decline.



STEP 4

To complete enrollment, click "Finalize," then "Sign and Submit".

HELPFUL TIPS

- Have your dependent/beneficiary information ready, such as Social Security numbers, before beginning the enrollment process.

EMPLOYEES

Visit the Help Menu for the most up-to-date version of this guide.

paycom

MEDICAL PLAN HIGHLIGHTS

CharterLIFE
Believe Build Benefit

Anthem EPO MEDICAL PLANS

EPO (Exclusive Provider Organization)

You have three EPO plan options with Anthem – High, Low and Base. Please note that you are not allowed to change the plan in the middle of the plan year unless you experience a Qualifying Life Event. For more information, please refer to page two: Enrolling in Your Benefits. You can change the plan only during the open enrollment period.

2022 HMO (SC 3 T) Annual Benefit Comparison

EPO Medical Benefits				
EPO		Anthem High^ $10	Anthem Low^ $30/$40	Anthem Base^ $35/$45
Benefits				
Annual Deductible	**Employee**	**None**	**None**	**None**
	Family	**None**	**None**	**None**
Out of Pocket Maximum*	**Employee**	**$2,000**	**$2,500**	**$2,500**
	Family	**$4,000**	**$5,000**	**$5,000**
Office Visit /Specialist**		**$10/$30**	**$30 / $40**	**$35 / $45**
Lab & X-Rays~		No Charge	No Charge	No Charge
Inpatient Hospital		$250 per admit	$500 per admit	$750 per admit
Outpatient (Surgery Services)		$125 per admit	$250 per admit	$375 per admit
Rehabilitative/Chiropractic^^		$10	$30	$35
Urgent Care		$10	$30	$35
Emergency Room		$100 (waived if admitted)	$100 (waived if admitted)	$100 (waived if admitted)
Prescription Drugs				
Tier 1- Generic		1a: $5/b:$15	1a: $5/1b:$15	1a: $5/ 1b: $15
Tier 2- Preferred Brand		$30	$25	$30
Tier 3 - Non- Preferred		$50	$45	$50
Tier 4 - Specialty Drugs*		30% Coinsurance (not to exceed $250)	30% Coinsurance (not to exceed $250)	30% Coinsurance (not to exceed $250)
Annual Rx Deductible		None	Ind: $150; Fam: $450	Ind: $150; Fam: $450

*All copayments for prescription drugs and prescription drug deductible amounts, when applicable, will apply to the Out of Pocket Maximum. **Preventive Services covered at 100%. ~If available through and authorized by medical group. ^^Additional co-pays and/or coinsurance may apply depending upon rendered services. The information presented in this chart is a summary only. For a complete understanding of benefits refer to Evidence of Coverage (EOC). Rates are subjected to specific guidelines and terms

Email: info@CharterLIFE.org **Call:** 888.392.3928 **Or visit us at:** www.CharterLIFE.org

Administered by: Benefit & Risk Management Services, Inc. **Address:** PO Box 2080, Folsom, CA 95630

Secure Email: CharterLIFE@brmsonline.com **Phone:** 866.755.6651 **Fax:** 855.392.3939

In Partnership With Dickerson Insurance Services License# OF69768

2022_SC_Annual_Rates_EPO_Benefits_SS_FINAL_no_bor_10.27.21_DB_v.1

CharterLIFE
Believe Build Benefit

Kaiser HMO MEDICAL PLANS

HMO (Health Maintenance Organization)

This is a type of plan in which medical costs are controlled by limiting services to a specific network of hospitals, doctors, other providers and usually by requiring referral by a primary-care physician for specialty care.

You have four HMO plan options with Kaiser – High, Low, HDP $1,500, and HRA $3,000. Please note that you are not allowed to change the plan in the middle of the plan year unless you experience a Qualifying Life Event. For more information, please refer to page two: Enrolling In Your Benefits. You can change the plan only during the open enrollment period.

2022 HMO (SC 3 T) Annual Benefit Comparison

HMO Medical Benefits					
HMO		**Kaiser High $10**	**Kaiser Low $20**	**Kaiser HDP $1500**	**Kaiser HRA $3000**
Benefits					
Annual Deductible	**Employee**	**None**	**None**	**$1,500**	**$3,000**
	Family	**None**	**None**	**$3,000**	**$6,000**
Out of Pocket Maximum*	**Employee**	**$1,500**	**$1,500**	**$4,000**	**$6,000**
	Family	**$3,000**	**$3,000**	**$8,000**	**$12,000**
Office Visit /Specialist**		**$10**	**$20**	**$20**	**20%**
Lab & X-Rays~		No Charge	No Charge	$10	20%
Inpatient Hospital		No Charge	$250 per admit	20% Coinsurance after Deductible	20%
Outpatient (Surgery Services)		$10	$20	20% Coinsurance after Deductible	20%
Rehabilitative/Chiropractic^^		$15 / 30 visits	$15 / 30 visits	$20	20%
Urgent Care		$10*	$20*	$20	20%
Emergency Room+		$150	$150	20% Coinsurance after Deductible	20%
Prescription Drugs					
Tier 1- Generic		Generic: 1a:$10/1b:$20	Generic:1a:$15/1b:$30	Generic: 1a:$10/1b:20	20% up to $50
Tier 2- Preferred Brand		Formulary Brand:1a:$25/1b:$50	Formulary Brand: 1a:$30/1b:$60	Formulary Brand:1a:$30/1b:$60	20% up to $100
Tier 3 - Non- Preferred		N/A	N/A	N/A	20% up to $200
Tier 4 - Specialty Drugs*		20% Coinsurance (not to exceed $150)	20% Coinsurance (not to exceed $200)	20% Coinsurance (not to exceed $150)	20% Coinsurance (not to exceed $200)
Annual Rx Deductible		None	None	None	None

*All copayments for prescription drugs and prescription drug deductible amounts, when applicable, will apply to the Out of Pocket Maximum. **Preventive Services covered at 100%. ~If available through and authorized by medical group. ^^Additional co-pays and/or coinsurance may apply depending upon rendered services. +If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share instead of the Emergency Department Cost Share. The information presented in this chart is a summary only. For a complete understanding of benefits refer to Evidence of Coverage (EOC). Rates are subjected to specific guidelines and terms.

CharterLIFE
Believe Build Benefit

Anthem PPO MEDICAL PLANS

PPO (Preferred Provider Organization)

This is a type of plan in which insurance carriers' contract with physicians, hospitals and other healthcare providers that will provide services at discounted (negotiated) rates. One of the advantages of a PPO plan is a great deal of flexibility. Members can receive medical care without a referral from their primary care physician. Members also have access to providers; who do not have a contract with the carrier (out-of-network providers), however benefits are reduced under the plan.

How Do You Find a Network Provider?

There are several ways:

- ☎Contact Anthem Blue Cross at 800-227-3670 (PPO), 866-207-9878 (HSA)
- Go to www.anthem.com/ca and click "Find a Doctor."

You have three PPO plan options with Anthem – High, Low, and Base. When you make an appointment with a doctor, please ask two questions: **1)"Are you contracted with Anthem Blue Cross?" Do not ask "Do you take PPO?"** since most providers take PPO insurance even if they are not contracted. **2)"Can you please confirm that the attending physician accepts my health plan?" Do not assume that all providers in a medical group accept your plan, as this may be optional.**

2022 PPO (SC) Benefit Comparison

PPO Medical Benefits							
PPO		Anthem High		Anthem Low		Anthem Base (HSA)	
		In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Annual Deductible^	Employee	$500	$1,000	$1,500	$4,500	$6,100^	$18,300^
	Family	$1,000	$2,000	$3,000	$9,000	$12,200^	$36,600^
Out of Pocket Maximum*	Employee	$1,500	$3,000	$3,500	$10,500	$6,400	$19,200
	Family	$3,000	$6,000	$7,000	$21,000	$12,800	$38,400
Office Visit /Specialist**		$20	70%	$15	40%	0%	50%
Lab & X-Rays^^		90%	70%	20%	40%	0%	50%
Inpatient Hospital~		90%	$500 per admit + 70% after deductible	20%	$500 per admit + 40% after deductible	0%	50% ($1000/Day benefit max)
Outpatient (Surgery Services)"		10%	30%	80%	60%	0%	50%
Rehabilitative/Chiropractic		$20	30%	$15	40%	0%	50%
Urgent Care		$20	30%	$15	40%	0%	50%
Emergency Room		$150 deductible (deductible waived if admitted)		$150 deductible + 20% coinsurance (deductible waived if admitted)		100%	
Prescription Drugs							
Tier 1- Generic		1a: $5/ 1b: $15	1a & b: 50% coinsurance up to $250	$10	50% coinsurance up to $250	1a: $5/ 1b:$15	1a & b: 50% coinsurance up to $250
Tier 2- Preferred Brand		$25	50% coinsurance up to $250	$35	50% coinsurance up to $250	$50	50% coinsurance up to $250
Tier 3- Non-Preferred		$45	50% coinsurance up to $250	$70	50% coinsurance up to $250	$65	50% coinsurance up to $250
Specialty Drugs*‡		30% up to $250	50% up to $250	30% up to $250	50% up to $250	30% up to $250	50% up to $250
Annual Rx Deductible		None		$150 per member/ $450 family		^Combined, Medical & Pharmacy Deductible	

~The maximum payment for non-emergency inpatient services received from a non-participating provider is limited to $1,000 per day. ^^Additional co-pays and/or coinsurance may apply depending upon rendered services. "The maximum payment for non-emergency outpatient services received from a non-participating provider is limited to $350 per admission. For a complete understanding of benefits refer to Evidence of Coverage (EOC). Rates are subjected to specific guidelines and terms.

Email: info@CharterLIFE.org **Call:** 888.392.3928 **Or visit us at:** www.CharterLIFE.org

Administered by: Benefit & Risk Management Services, Inc. **Address:** PO Box 2080, Folsom, CA 95630

Secure Email: CharterLIFE@brmsonline.com **Phone:** 866.755.6651 **Fax:** 855.392.3939

In Partnership With Dickerson Insurance Services License# OF69768

DENTAL PLAN HIGHLIGHTS

CharterLIFE
Believe Build Benefit

Delta Dental DENTAL PLANS

How Do You Find a Network Provider?

There are several ways:

☎Contact Delta Dental at 800-422-4234 (HMO), 800-765-6003 (PPO).
Go to www.deltadentalins.com

You have three plan options with Delta Dental – HMO, PPO 1000, and PPO 2000. When you have a PPO plan and make an appointment with a dentist, please ask **"Are you contracted with Delta Dental, and are you a Premier PPO network or DeltaCare network provider?"** Do not ask **"Do you take PPO?"** since most providers take PPO insurance even if they are not contracted. Additionally, Delta has various classifications for PPO providers.

2022 Dental Benefit Comparison

DENTAL BENEFIT COMPARISON						
Tier		**Dental PPO 2000**		**Dental PPO 1000**		**DeltaCare DHMO**	
		In Network	Out of Network	**In Network**	Out of Network	**In Network**	Out of Network
Annual Maximum Benefit		**$2,000**		**$1,000**		**Unlimited**	
Annual Deductible	**Individual**	**$50**		**$50**		**No Deductible**	
	Family Limit	$150 per family		$150 per family		**No Deductible**	
Deductible Waived		**Preventive**		**Preventive**		**No Deductible**	
Preventive Care		**100%**	100%	**100%**	100%	Network Only - You pay a co-pay for each covered procedure. Please refer to your Plan Details for additional information.	
Basic Care		**80%**	60%	**80%**	60%		
Major Care		**50%**	40%	**50%**	40%		
Orthodontia		**50%**	50%	**50%**	50%		

The information presented in this chart is a summary only. For a complete understanding of benefits refer to Evidence of Coverage (EOC).

*Rates are for those members who also participate in CharterLIFE Medical Plans.

Email: info@CharterLIFE.org **Call:** 888.392.3928 **Or visit us at:** www.CharterLIFE.org

Administered by: Benefit & Risk Management Services, Inc. **Address:** PO Box 2080, Folsom, CA 95630

Secure Email: CharterLIFE@brmsonline.com **Phone:** 866.755.6651 **Fax:** 855.392.3939

In Partnership With Dickerson Insurance Services License# OF69768

VISION PLAN HIGHLIGHTS

VSP VISION PLAN

How do you find a network provider?

There are several ways:

☎Contact VSP at 800-877-7195.
Go to www.vsp.com.

Vision Plan	In-Network	Out-of-Network
Frequency of Service (Exam/Lenses/Frames)	12 Months/12 Months/12 Months	
Copay	$10 for Exam, $25 for Materials	
Exam	Covered in Full	Reimburse up to $50
Lenses		
Single Vision	Covered in Full	Reimburse up to $50
Bifocal	Covered in Full	Reimburse up to $75
Trifocal	Covered in Full	Reimburse up to $100
Frames	$200 Allowance, then 20% off remaining balance	Reimburse up to $70
Contacts	Up to $60 copay with $150 Allowance	Reimburse up to $105

The above information is for explanation purpose only.
Please refer to Evidence of Coverage for complete details of plan benefits, limitations and exclusions.

HOW TO FILE CLAIMS

If you use the network, you do not need to submit a claim form. The provider will file it and receive payment directly from the carriers. The provider will bill you if there is any balance.

You may be asked to pay upfront and submit a claim to get reimbursed if you use an **out of network provider**. Claim forms can be downloaded and printed out from the VSP website at www.vsp.com, login to your Vbas account or call customer service at 1.866.755.6651. You must fill out the form and send it to the carrier with a copy of the itemized receipt.

Reminder, you can now utilize your VSP benefits at your local Costco!

LIFE/AD&D PLAN HIGHLIGHTS

CharterLIFE
Believe Build Benefit

Unum Basic Life/AD&D

Da Vinci Schools offers Life and Accidental Death & Dismemberment benefits to give your family financial peace of mind if anything should happen to you.

PLEASE UPDATE BENEFICIARY INFORMATION IF NEEDED, SO THAT THE LIFE BENEFIT WILL BE PAID TO YOUR DESIGNATED BENEFICIARY. Please contact your HR representative, CharterLIFE member services at CharterLIFE@brmsonline.com or call 1.866.755.6651 to request an update/change your beneficiary. You may also go online at www.Vbas.com.

Basic Life	$25,000
Accidental Death & Dismemberment	$25,000
Age Reduction	Reduced to 65% at age 70, to 50% at age 75.

The above information is for explanation purpose only.
Please refer to Evidence of Coverage for complete details of plan benefits, limitations and exclusions.

SUPPLEMENTAL LIFE PLAN HIGHLIGHTS

CharterLIFE
Believe Build Benefit

Unum Supplemental Life

In addition to the basic coverage provided through Da Vinci Schools you also have an opportunity to purchase supplemental life protection from Unum. Availability of this benefit is subject to minimum participation levels. In the event of insufficient participation, this coverage will no longer be provided. Please call customer service at 800-421-0344 for additional information about this program.

Employee Election Amount	**Up to 5 times salary in increments of $10,000, not to exceed $500,000.**
Employee Guaranteed Issue Amount	$200,000
Spouse Life Benefits	Up to 100% of employee amount in increments of $5,000, not to exceed $100,000.
Spouse Guaranteed Issue Amount	$50,000
Infant/Child Life Benefits	Up to 100% of employee coverage amount in increments of $2,000, not to exceed $10,000. The maximum death benefit for a child between the ages of live birth and six months is $2,000.

LIFE	Employee and Spouse Rate per $1,000
< 25	$0.070
25-29	$0.070
30-34	$0.080
35-39	$0.100
40-44	$0.150
45-49	$0.260
50-54	$0.043
55-59	$0.680
60-64	$1.060
65-69	$1.900
70-74	$3.390
75 +	$5.600
Child	$0.160

AD&D	Employee and Spouse Rate per $1,000
Employee	$0.02
Spouse	$0.02
Child	$0.02

The above information is for explanation purpose only.
Please refer to Evidence of Coverage for complete details of plan benefits, limitations and exclusions.

Travel Assistance Program

Travel assistance program provides help for members away from home (100 miles or more) to find and obtain emergency medical care in an unfamiliar place, and to return members home when stabilized.

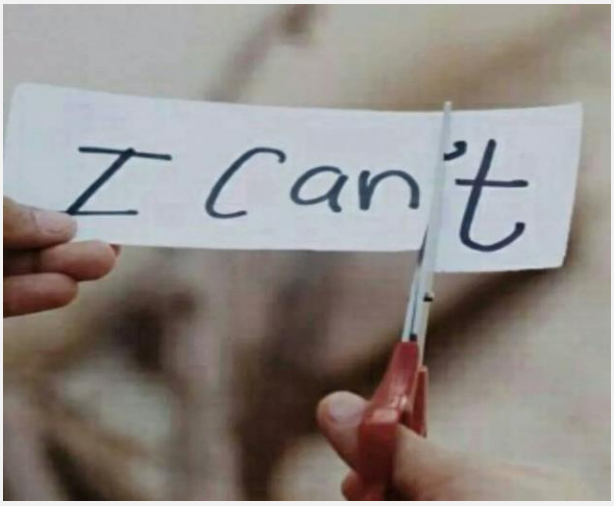
When you experience a medical emergency, you can call Assist America to receive help. Please call customer service at 800-421-0344 for additional information about this program. Medically certified personnel can connect you with pre-qualified, English-speaking and Western-trained medical providers anywhere in the world 24 hours a day, 7 days a week.

Employee Assistance Program (EAP)

Da Vinci Schools offers you and your family members access to EAP benefits, administered by Unum. This important benefit is designed to help you and your family with issues that affect your personal and professional lives. The information you share with the EAP counselor (and any outside resource) is completely confidential. You may receive up to three face-to-face counseling sessions.*

*This benefit is available 24 hours a day, 7 days a week to discuss personal and professional concerns related to but not limited to the following issues:

- Marital or family concerns
- Interpersonal problems
- Stress and emotional distress
- Alcohol and drug abuse
- Job-related problems
- Child and elder care consultations



ADDITIONAL INFORMATION

When using your insurance plan, remember the following…

Below you will find helpful information on ways to maximize your benefits, and important things to remember when using your insurance plan benefits.

Advantage of PPO Providers

- Within the provider contract, insurance carriers set allowable charges for all procedures. PPO providers are prohibited from charging more than the allowable charge.
- On the other hand, there is no set agreement between insurance carriers and Non-PPO providers. Non-PPO providers can charge any amount. Therefore, the insurance carrier sets the maximum amount that is considered eligible for reimbursement based on geographical data. When a non-PPO provider charges more than the maximum amount, you are going to be responsible for any excess amount.

For example, under the dental plan, you had a crown. (Insurance carrier pays at 50%. Assuming you had met the $50 deductible):

Provider charge was $800, Allowable charge was $400, Maximum amount for non-PPO providers was $600

In Network		Out of Network	
Allowable charge	$400	Provider Charge	$800
Insurance Payment (50%x$400)	-$200	Insurance Payment (50%x$600)	-$300
Your Responsibility	**$200**	**Your Responsibility**	**$500**

How to Search PPO Providers

- There are a couple of ways to search providers:
  - ✓ Call the insurance company's customer service number (on your ID card)
  - ✓ Check the provider directory on the insurance carrier's website
  - ✓ Call and verify coverage with the provider (are you contracted with ABC insurance company?)
- The easiest way would be checking the carrier website; however, the information may not be up-to-date depending on how frequently the carrier updates their system. In case you are planning to have an expensive procedure (surgery, etc.), we recommend you call the provider directly.

Explanation of Benefits (EOB)

- The EOB is a statement that shows how much should be paid, and by what party.
- If your out-of-pocket payment amount on an EOB is different from the amount charged by the provider, there may be an error. We recommend you **contact Merica Mojica at Dickerson Insurance Services at (323) 662-7810**, so that we can investigate the details on your behalf.

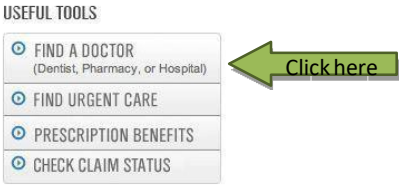
Anthem Blue Cross

Find a Provider Tool

Large Group Client: Southern California - Charterlife

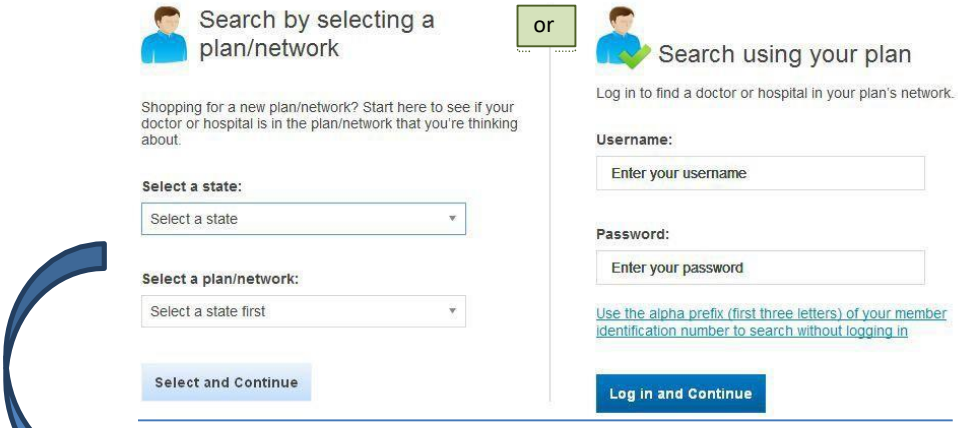
Step 1:

Go to: www.Anthem.com/ca



Step 2:

There are two ways to search for a doctor. Doctors can be searched by selecting your plan/network options or by entering the member's login information to access their personalized online profile.



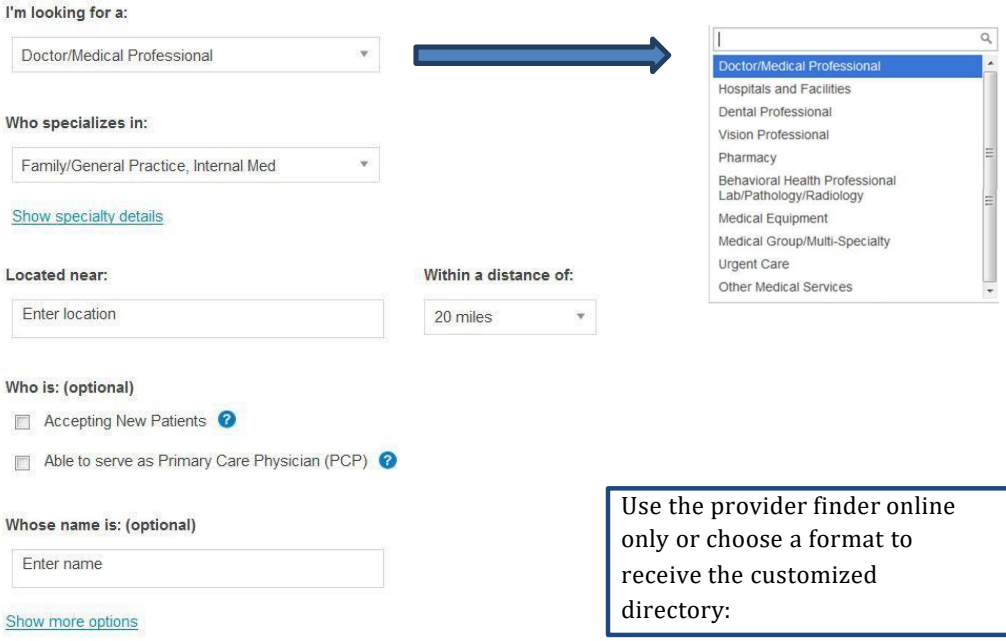
1. ***Select a state:*** **California**
2. ***Select a plan/network:***

Medical (Employer-Sponsored)

Behavioral Health Network (EPO)
Behavioral Health Network (PPO)
Blue Cross EPO (CACare) – Large Group
Blue Cross PPO (Prudent Buyer) – Large Group
EPO
HMO Chiropractic/Acupuncture Network (American Specialty Health Plans)
Lumenos Plans
National PPO (BlueCard PPO)
Priority Select EPO
Select EPO
Select Plus EPO

Step 3:

Complete the steps below to find a doctor.



Use the provider finder online only or choose a format to receive the customized directory:

Email Fax Print

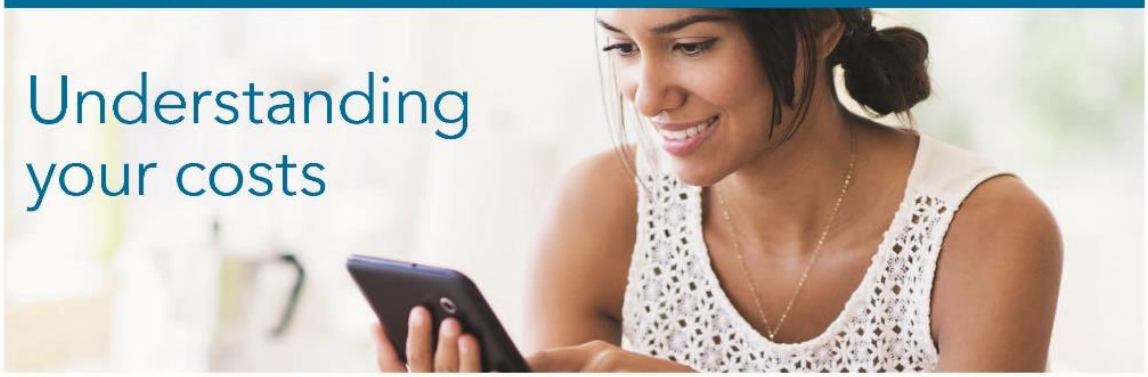
Once you press Search you will get a listing of doctors. You can refine your search results after you get a listing.

Important to Remember for EPO:

- EPO care is managed by the medical group you choose.
- Make sure the doctor you choose has a contract with the medical group you select.
- Make sure the medical group you select is part of the correct network (Select or Traditional)
- If you are trying to coordinate to have the opportunity to utilize a specific hospital, make sure that both the doctor and medical group have contracts with that hospital. However, it is up to the medical group as to which hospitals they utilize regardless of contracts
- For member to get to use a specific hospital for non-emergencies certain requirement must be met:
  - The hospital must be in Anthem's network of contracted hospitals.
  - The admitting doctor must have admitting privileges at that hospital.
  - The medical group must approve the hospital admission. The medical group may send the member to a different facility.

For Kaiser Permanente Deductible Plan Members

Understanding your costs



With your deductible plan, you'll pay the full charges for covered services until you reach your deductible. Then you'll start paying less – a copay or a coinsurance.* These steps show what to expect before, during, and after your visit – so you can avoid surprises and better understand and manage your health care costs.

1 Before your visit

Get an estimate

Visit **kp.org/costestimates** for an estimate of what you'll pay for common services. Estimates are based on your plan benefits and whether you've reached your deductible – so you get personalized information every time.

You can also call **1-800-390-3507,** weekdays from 7 a.m. to 5 p.m.

Visit kp.org/deductibleplans

You'll find a wide range of information and resources to help you understand your plan and manage your costs.

2 During your visit

Pay when you check in

When you come in for care, you'll be asked to make a payment for your scheduled services.†

Your payment may only cover part of what you owe for your visit, especially if you get any additional services. In that case, you'll get a bill for the difference later.

Expect a bill for additional services

During your visit, your doctor may decide you also need services that weren't scheduled – like a blood test or an X-ray. If what you pay for these services doesn't cover everything you owe, you'll get a bill later.

3 After your visit

Understand your bills

You'll get a bill after most visits. It will show the charges for the services you got, what you paid, what your health plan paid, and the amount you owe.

You can pay your bill:

- Online anytime at **kp.org/paymedicalbills**
- By mail
- By phone at **1-800-390-3507,** weekdays from 7 a.m. to 5 p.m.

Track your expenses

You'll also get an Explanation of Benefits (EOB). It isn't a bill. It's a summary of your services and charges, and shows how close you are to reaching your deductible and out-of-pocket maximum. Visit **kp.org/mydocuments** anytime to see your EOBs online.

See the next page for important terms and more information about services that can result in a bill.

*Depending on your plan, you may pay copays or coinsurance for some services without having to reach your deductible.

†If your plan comes with a flexible spending account (FSA), health reimbursement arrangement (HRA), or health savings account (HSA), you can pay using the debit card for your account, if you have one. Use it when you check in for your visit or when paying your bill later.

kp.org/deductibleplans

KAISER PERMANENTE®

CharterLIFE™
Believe Build Benefit

When a preventive visit includes non-preventive care

Preventive care services are an important part of catching health problems early – that's why they're covered at no cost or at a copay.* But sometimes when you come in for preventive care, you'll get non-preventive services too, which you'll need to pay for.

For example, during a routine physical exam, your doctor might find a mole and remove it for testing. Because the mole removal and testing are non-preventive services, you'll get a bill for them later.

Have questions or need help paying for care?

Call **1-800-390-3507,** weekdays from 7 a.m. to 5 p.m., if you have questions about your costs or bills. You can also get information about financial assistance and payment options available for members who need help paying for care.

Important terms

Deductible
The amount you pay for covered services each year before your health plan starts paying. Depending on your plan, you may pay copays or coinsurance for some services without having to reach your deductible.

Copay
The set amount you pay for covered services. For example, a $10 copay for an office visit.

Coinsurance
A percentage of the charges that you pay for covered services. For example, a 20% coinsurance for a $200 procedure means you pay $40.

Out-of-pocket maximum
The most you'll pay for covered services each year. For a small number of services, you may need to keep paying copays or coinsurance after reaching your out-of-pocket maximum.†

*Depending on your plan, preventive care services are covered at no cost or at a copay. For more information, see your *Evidence of Coverage* or *Summary Plan Description*.

†If you have an HSA-qualified deductible plan, once you reach your out-of-pocket maximum, you won't have to pay anything for covered services for the rest of the year. If you are enrolled through a group's self-funded EPO plan, your health benefits are self-insured by your employer, union, or Plan sponsor. Kaiser Permanente Insurance Company provides certain administrative services for the Plan and is not an insurer of the Plan or financially liable for health care benefits under the Plan.

Kaiser Permanente does not discriminate on the basis of age, race, ethnicity, color, national origin, cultural background, ancestry, religion, sex, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, source of payment, genetic information, citizenship, primary language, or immigration status.

Language Assistance Services

English: We provide interpreter services at no cost to you, 24 hours a day, 7 days a week, during all hours of operation. You can have an interpreter help answer your questions about our health care coverage. You can also request materials translated in your language at no cost to you. Just call us at **1-800-464-4000,** 24 hours a day, 7 days a week (closed holidays). TTY users call **711.**

Spanish: Ofrecemos servicios de traducción al español sin costo alguno para usted durante todo el horario de atención, 24 horas al día, siete días a la semana. Puede contar con la ayuda de un intérprete para responder las preguntas que tenga sobre nuestra cobertura de atención médica. Además, puede solicitar que los materiales se traduzcan a su idioma sin costo alguno. Solo llame al **1-800-788-0616,** 24 horas al día, siete días a la semana (cerrado los días festivos). Los usuarios de TTY, deben llamar al **711.**

Chinese: 我們每週 7 天， 每天24小時在所有營業時間內免費爲您提供口譯服務。 您可以請口譯員協助回答有關我們健康保險的問題。 您也可以免費索取翻譯成您所用語言的資料。 我們每週7天， 每天24小時均歡迎您打電話 **1-800-757-7585** 前來聯絡（節假日 休息）。 聽障及語障專線 (TTY) 使用者請撥 **711**。

KAISER PERMANENTE®

Please recycle. 60538830 December 2016

- For some procedures (hospitalization, outpatient surgery, etc.), insurance carriers require pre-authorization. When you go to non-PPO providers, you are the one responsible for filing the pre-authorization. PPO providers do file pre-authorizations on behalf of patients; however, you may want to confirm with your provider that it was filed.
- For dental treatment, **it is recommended** that you have your dentist submit a request for a **pre-treatment estimate** for services in excess of $300 to Delta Dental by submitting a claim form along with the proposed treatment plan. A pre-treatment estimate will be sent to you and the dentist detailing an estimate of what services your plan will cover and at what payment level.

Types of Prescription Drugs

- Generally, prescription drugs can be separated into two categories (Generic and Brand). Brand name drugs are patent protected (manufactured and sold by only one pharmaceutical company) and tend to be very expensive. On the other hand, Generic drugs are no longer patent protected, and multiple pharmaceutical companies are able to produce these drugs with same or similar effects as Brand name drugs. Generic drugs are less expensive. Therefore, in the event that a doctor prescribes a Brand name drug, it is highly recommended that the patient (employee or dependent) ask the doctor for a Generic alternative.
- In the event that multiple Brand name drugs can be used for the same medical condition, the insurance carrier specifies which Brand name drug is preferred. The insurance carrier's drug list for these types of drugs is called the Formulary Drug List. Purchasing Non-Preferred Brand drugs will be more costly.
- The Formulary Drug List can be found on the insurance carrier's website. It is important to note that some carriers may change their Formulary Drug List every ninety days.

Mail Order Prescription Service

- For prescription drugs taken on a regular basis, you can take advantage of the insurance carrier's mail order service.
- Out-of-pocket costs may be cheaper when using this service.

Emergency Services

- Unless you have a "life threatening" condition, you should go to an Urgent Care Center instead of the Emergency Room. Compared to hospital emergency rooms, you are usually able to see a doctor quicker. Your payment may also be less. It is important to know the location of your local Urgent Care centers nearby in advance.

Helpful Health Insurance Terms

The health care system in the United States can be confusing. In order to get the most out of your health care benefits, you need to understand the terms used by insurance companies, health plans and health care providers. This way, you can make better decisions and ultimately receive better care.

- **Ambulatory Care** – Health care services that do not require a hospital stay, such as those delivered in a doctor's office, clinic or day surgery center.
- **Assignment of Benefits** – This means signing a document that allows your hospital or doctor to collect your health insurance benefits directly from your health carrier. Otherwise, you pay for treatment and the insurance company reimburses you.
- **Benefits** – The amount of money payable by an insurance company to a claimant under the insurance policy.
- **Capitation** – Represents a set dollar limit that a health maintenance organization (HMO) pays to your primary care physician for providing medical treatment to you and your dependents. The fee is usually paid to the physician on a monthly basis. The physician gets no more or less than this set fee, no matter how much or how little you use his or her services.
- **Case Management** – A technique that insurance companies and HMOs use to ensure that individuals receive appropriate, timely and reasonable health care services.
- **Claim** – A request by an individual (or his or her provider) for the insurance company to pay for services obtained.
- **Coinsurance** – The money that an individual is required to pay for services, after a deductible has been paid. It is often a specified percentage of the charges. For example, the employee pays 20 percent of the charges while the health plan pays 80 percent.
- **Copayment** – An arrangement where an individual pays a specified amount for various health care services and the health plan or insurance company pays the remainder. The individual must usually pay his or her share when services are rendered. The concept is similar to coinsurance, except that copayments are usually a set dollar amount (such as $20 per office visit), rather than a percentage of the charges.
- **Deductible** – A set dollar amount that a person must pay before insurance coverage for medical expenses can begin. They are usually charged on an annual basis.
- **Denial of claim** – Refusal by an insurance company to pay a submitted request for health care services obtained.
- **Exclusions and Limitations** – Specific conditions or circumstances for which an insurance policy or plan will not provide coverage (exclusions), or for which coverage is specifically limited (limitations).
- **Health Maintenance Organization (HMO)** – Prepaid, or capitated, health care plans in which individuals pay a small monthly fee to be a member of the HMO, as well as small fees or copayments for specified health care services. Services are provided by physicians and allied health care personnel who are employed by or under contract with the HMO. HMOs are available to both individuals and employer groups.

- **In-Network** –Typically refers to physicians, hospitals or other health care providers who contract with the insurance plan (usually an HMO or PPO) to provide services to its members. Coverage for services received from in-network providers will typically be greater than for services received from out-of-network providers, depending on the plan.
- **Long-Term Care Insurance** – Insurance policies that cover the costs of providing nursing care, home health care services, and custodial care for the aged and infirm.
- **Managed Care** – A system of health care delivery that is characterized by arrangements with selected providers, ongoing quality control and utilization review programs, and financial incentives for members to use providers and procedures covered by the plan.
- **Maximum Benefit** – The maximum dollar amount that an insurance company will pay for claims, either for a specific service or procedure, or during a specified period of time.
- **Medically Necessary** – A term used to describe the supplies and services needed to diagnose and treat a medical condition in accordance with the standards of good medical practice. Many health plans will only pay for treatment deemed medically necessary. For example, most plans will not cover elective cosmetic surgery.
- **Out-of-Network** – Typically refers to physicians, hospitals or other health care providers who do not contract with the insurance plan (usually an HMO or PPO) to provide services to its members. Depending upon the insurance plan, expenses incurred for services provided by out-of-network providers might not be covered, or coverage may be less than for in-network providers.
- **Out-of-Pocket Maximum** – The total amount paid each year by the member for the deductible and coinsurance. After reaching the out-of-pocket maximum, the plan pays 100 percent of the allowable charges for covered services the rest of that calendar year.
- **Pre-Admission Certification** – Also called "precertification" or "pre-admission review." Approval granted by a case manager or insurance company representative (usually a nurse) for a person to be admitted to a hospital or inpatient facility before admittance. The goal is to ensure that individuals are not exposed to inappropriate health care services, or services that are not medically necessary.
- **Pre-Existing Condition** –Any medical condition that was diagnosed or treated within a specified period immediately before a health insurance policy became effective. These conditions may not be covered for a specified period of time under the new policy.
- **Preferred Provider Organization (PPO)** – A type of managed care plan in which doctors and hospitals agree to provide discounted rates to plan members. Patients are typically reimbursed 80 to 100 percent for treatment received within the network, versus 50 to 70 percent outside the network.
- **Primary Care Physician (PCP)** – A health care professional who is responsible for monitoring an individual's overall health care needs. Typically, a PCP serves as a gatekeeper for an individual's medical care, referring him or her to specialists and admitting him or her to hospitals when needed.
- **Reasonable and Customary Charges** – The commonly charged or prevailing fees for health services within a geographic area. If charges are higher than what an insurance carrier considers reasonable and customary, the carrier will not pay the full amount and instead will pay what is deemed appropriate for the particular service. The remaining charges then are the responsibility of the patient.
- **Waiting Period** – A period of time in which your health plan does not provide coverage for a particular pre-existing condition.