

GEMCare Health Plan: Plan B

Coverage Period: 9/1/2013 to 8/31/2014

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

Coverage for: Individual/Family | Plan Type: HMO



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.gemcarehealthplan or by calling 1-800-697-2464.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$ 0.00	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?	Yes. Individual \$1500/Family \$3000	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, deductibles, prescription drugs and health care this plan does not cover.	The out-of-pocket limit does not include premiums, balance-billed charges, deductibles, if applicable, prescription drugs and health care that this plan does not cover. Even though you play these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	Yes. Only on specific benefits (DME up to \$2,000 except in special cases, Home Visits up to 100 visits, except in special cases, etc.)	For most benefits the plan does not have a limit on what it will pay. However, this plan will pay for covered services only up to this limit for specific benefits during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit for those specific benefits . 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. For a list of preferred providers , see www.gemcarehealthplan.com or call 1-877-697-2464.	If you use an in-network doctor or other health care provider , 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 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 ?	Yes. However members may self-refer to an in-network	This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist .

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OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

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	specialist at a higher copay.	
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services .

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- **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		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20	100%	
	Specialist visit	\$20	100%	Prior authorization from the plan is required.
	Other practitioner office visit	\$20	100%	Prior authorization from the plan is required
	Preventive care/screening/immunization	\$0	100%	
If you have a test	Diagnostic test (x-ray, blood work)	\$0	100%	
	Imaging (CT/PET scans, MRIs)	\$0	100%	Prior authorization from the plan is required.
If you need drugs to treat your illness or condition	Generic drugs	\$15	100%	
	Preferred brand drugs	\$30	100%	
	Non-preferred brand drugs	\$45	100%	
More information about prescription drug coverage is available at www.[insert].	Specialty drugs	\$45	100%	Some medications may require prior authorization by the plan.

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		In-network Provider	Out-of-network Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100	100%	Prior authorization from the plan is required.
	Physician/surgeon fees	\$0	100%	Prior authorization from the plan is required.
If you need immediate medical attention	Emergency room services	\$100	100%	
	Emergency medical transportation	\$100	\$100	
	Urgent care	\$50	100%	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 per admission	100%	
	Physician/surgeon fee	\$0	\$100	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$20	100%	
	Mental/Behavioral health inpatient services	\$250 per admission	100%	
	Substance use disorder outpatient services	\$20	100%	
	Substance use disorder inpatient services	\$250 per admission	100%	For detoxification; rehabilitation is not covered (except for individuals treated for Behavioral Health Therapy diagnosed with PDD / Autism).
If you are pregnant	Prenatal and postnatal care	\$0	100%	
	Delivery and all inpatient services	\$250 per admission	100%	

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Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you need help recovering or have other special health needs	Home health care	\$0	100%	Coverage is limited to 100 visits. (Individuals receiving Behavioral Health Therapy for PDD or Autism not subject to any visit limit for home health care benefits).
	Rehabilitation services	\$20	100%	Prior authorization required by the plan.
	Habilitation services		100%	
	Skilled nursing care	\$75 per day	100%	Maximum of 100 days per calendar year
	Durable medical equipment	50%	100%	Coverage is limited to \$2,000 per calendar year. (DME provided in conjunction with mandated benefits (for example, pediatric asthma and/or diabetic treatment items (i.e., insulin pumps) are not subject to the benefit maximum.
	Hospice service	\$0	100%	
If your child needs dental or eye care	Eye exam	\$0 Preventative Vision Screening / \$20 Annual Refraction	100%	Vision and hearing screening by Personal Physician for Members through age 18 / Vision Refraction covered one time per year
	Glasses	Not covered	100%	
	Dental check-up	Not covered	100%	

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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 (unless individual meets national guidelines for the morbidly obese)	• Cosmetic Surgery
• Dental Care (Adult)	• Hearing Aids	• Infertility Treatment
• Long-term Care	• Private-duty nursing	• Routine Eye care (Adult – except annual refractions)
• Routine Food Care	• Weight loss programs (unless individual meets national guidelines for the morbidly obese)	

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

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 [contact number]. 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.”

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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:

- **GEMCare Health Plan** at 1-877-697-2464 or 1-888-933-9312 (TTY) / send a letter to 4550 California Avenue, Suite 100, Bakersfield, CA 93309 or visit our website: **www.gemcarehealthplan.com** under Member Rights.
- Additionally, a consumer assistance program can help you file your appeal. Contact California's Help Center (part of the Department of Managed Health Care (DMHC) at: Call 1-888-466-2219 / Email: **helpline@dmhc.ca.gov** / or visit the web-site **www.hmohelp.ca.gov**.

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

Language Access Service:

SPANISH (Español): Para asistencia en español por favor llame al 1-877-6608

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 \$7120**
- **Patient pays \$420**

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
Co-pays	\$270
Co-insurance	\$0
Limits or exclusions	\$150
Total	\$420

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

- **Amount owed to providers: \$4,100**
- **Plan pays \$2870**
- **Patient pays \$1230**

Sample care costs:

Prescriptions	\$1,500
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$730
Education	\$290
Laboratory tests	\$140
Vaccines, other preventive	\$140
Total	\$4,100

Patient pays:

Deductibles	\$
Co-pays	\$900
Co-insurance	\$250
Limits or exclusions	\$80
Total	\$1230

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 expenses.

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