

Anthem Blue Cross County Of San Diego – Anthem HMO SELECT PLAN

Coverage Period: 01/01/2015 - 12/31/2015

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

Coverage for: All Coverage Types | 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 <http://www.anthem.com/ca> or by calling 1-800-227-3771.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| What is the overall <u>deductible</u> ? | \$0. | See the chart starting on page 2 for your costs for services this plan covers. |
| Are there other <u>deductibles</u> 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 <u>out-of-pocket limit</u> on my expenses? | Yes. For In-Network Providers \$2,000 Individual/ \$4,000 Two-Party/ \$6,000 Family For Out-of-Network Providers \$0 Individual/ \$0 Two-Party/ \$0 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> ? | Infertility Services Copay, Premiums, Balance-billed charges and Health care this plan 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 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. See http://www.anthem.com/ca or call 1-800-227-3771 for a list of In-Network Providers. | 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> . |
| Do I need a referral to see a <u>specialist</u> ? | Yes. | This plan will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have the plan's permission before you see the <u>specialist</u> . |

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| | | |
|---|------|---|
| Are there services this plan doesn't cover? | Yes. | Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about excluded services . |
|---|------|---|



- **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 office</u> or clinic | Primary care visit to treat an injury or illness | \$25 Copay/Visit | Not Covered | -----none----- |
| | Specialist visit | \$40 Copay/Visit | Not Covered | -----none----- |
| | Other practitioner office visit | Chiropractor \$25 Copay/Visit Acupuncturist \$25 Copay/Visit | Chiropractor Not Covered Acupuncturist Not Covered | Chiropractor Coverage is limited to 60 days period of care for Physical, Occupational or Speech Therapy or Chiropractic care. Chiropractic visits count towards your physical and occupational therapy limit |
| | Preventive care/screening /immunization | No Cost Share | Not Covered | -----none----- |
| If you have a test | Diagnostic test (x-ray, blood work) | Lab – Office No Cost Share X-Ray – Office No Cost Share | Lab – Office Not Covered X-Ray – Office Not Covered | -----none----- |

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| 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 |
|--|--|---|--|--|
| | Imaging (CT/PET scans, MRIs) | \$100 Copay/Test | Not Covered | Costs may vary by site of service. You should refer to your formal contract of coverage for details. |
| <p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at https://www.anthem.com/ca/health-insurance/provider-directory/search/criteria?branding=ABC&provtype=Rx</p> | Tier 1 – Typically Generic <i>(includes diabetic supplies)</i> | \$10 Copay/prescription (retail and home delivery) \$20 Copay/prescription (home delivery) | \$10 Copay/ prescription plus 50% of the remaining prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowable | <p>For Non-Network: Member pays the retail pharmacy copay plus 50%. Covers up to a 30 day supply for Retail pharmacy or a 90 day supply for Home Delivery. For Non-Participating Pharmacies, compound drugs & certain specialty pharmacy drugs may require preauthorization or are not covered. 30-day supply; 60-day supply for Federally Classified Schedule II Attention Deficit Disorder drugs that require a triplicate prescription require double copay available only at a Retail Pharmacy.</p> |
| | Tier 2 – Typically Preferred/ Brand Name Formulary | \$20 Copay/prescription (retail) \$40 Copay/prescription (home delivery) | \$20 Copay/ prescription plus 50% of the remaining prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowable | |
| | Tier 3 – Typically Non-Preferred/Brand Name Non-Formulary Drugs <i>(includes compound drugs; retail only)</i> | \$35 Copay/prescription (retail) \$60 Copay/prescription (home delivery) | \$35 Copay/ prescription plus 50% of the remaining prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowable | |
| | Tier 4 – Typically Specialty Drugs <i>(includes self-administered injectable drugs/ except insulin)</i> | \$35 Copay/prescription (retail) \$60 Copay/prescription (home delivery) | \$35 Copay/ prescription plus 50% of the remaining prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowable | |

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|---|--|---|---|---|
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | \$100 Copay/Admit | Not Covered | -----none----- |
| | Physician/surgeon fees | No Cost Share | Not Covered | -----none----- |
| If you need immediate medical attention | Emergency room services | \$125 Copay/Visit | Covered as In-Network | This is for the hospital/facility charge only. The ER physician charge may be separate; copay waived if admitted. |
| | Emergency medical transportation | No Cost Share | Covered as In-Network | -----none----- |
| | Urgent care | \$40 Copay/Visit | Covered as In-Network | Copay waived if admitted inpatient and outpatient ER. Non-Network only covered when out of area. For in area, contact your PCP or medical group. Costs may vary by site of service. You should refer to your formal contract of coverage for details. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$200 Copay/Admit | Not Covered | -----none----- |
| | Physician/surgeon fee | No Cost Share | Not Covered | -----none----- |

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| 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 have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | Mental/Behavioral Health Office Visit \$25 Copay/Visit Mental/Behavioral Health Facility Visit – Facility Charges No Cost Share | Mental/Behavioral Health Office Visit Not Covered Mental/Behavioral Health Facility Visit – Facility Charges Not Covered | -----none----- |
| | Mental/Behavioral health inpatient services | No Cost Share | Not Covered | This is for facility professional services only. Please refer to your hospital stay for facility fee. |
| | Substance use disorder outpatient services | Substance Abuse Office Visit \$25 Copay/Visit Substance Abuse Facility Visit – Facility Charges No Cost Share | Substance Abuse Office Visit Not Covered Substance Abuse Facility Visit – Facility Charges Not Covered | -----none----- |
| | Substance use disorder inpatient services | No Cost Share | Not Covered | This is for facility professional services only. Please refer to your hospital stay for facility fee. |
| If you are pregnant | Prenatal and postnatal care | \$25 Copay/Visit | Not Covered | -----none----- |
| | Delivery and all inpatient services | \$200 Copay/Admit | Not Covered | -----none----- |

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| 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 Cost Share | Not Covered | Coverage is limited to 100 visits per Benefit Period; one visit by a Home health aide equals four hours or less. |
| | Rehabilitation services | \$25 Copay/Visit | Not Covered | Coverage is limited to 60 days period of care for Physical, Occupational or Speech Therapy or Chiropractic care. Costs may vary by site of service. You should refer to your formal contract of coverage for details. |
| | Habilitation services | No Cost Share | Not Covered | Services received in a Hospital, other than Emergency Room Services, or in any facility that is affiliated with a Hospital. Habilitation visits count towards your Rehabilitation limit. Costs may vary by site of service. You should refer to your formal contract of coverage for details. |
| | Skilled nursing care | No Cost Share | Not Covered | Coverage is limited to 100 days per Benefit Period. |
| | Durable medical equipment | No Cost Share | Not Covered | -----none----- |
| | Hospice service | No Cost Share | Not Covered | -----none----- |
| If your child needs dental or eye care | Eye exam | Not Covered | Not Covered | -----none----- |
| | Glasses | Not Covered | Not Covered | -----none----- |
| | Dental check-up | Not Covered | Not Covered | -----none----- |

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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.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (Unless you have been diagnosed with diabetes. Consult your formal contract of coverage.)
- 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.)

- Acupuncture
- Bariatric surgery (For morbid obesity, consult your formal contract of coverage.)
- Chiropractic 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 1-800-227-3771. 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:

Anthem Blue Cross
ATTN: Appeals or Grievance
P.O. Box 4310
Woodland Hills, CA 91367

Department of Managed Health Care California Help Center
980 9th Street, Suite 500
Sacramento, CA 95814-2725
1-888-HMO-2219

Or Contact:

Department of Labor's Employee Benefits
Security Administration at
1-866-444-EBSA(3272) or
www.dol.gov/ebsa/healthreform

A consumer assistance program can help you file your appeal. Contact:
California Department of Managed Health Care Help Center
980 9th Street, Suite 500
Sacramento, CA 95814
(888) 466-2219
<http://www.healthhelp.ca.gov>
helpline@dmhc.ca.gov

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.

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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 eí dooda'i, shikáa adoolwol íinízinigo t'áá diné k'éjúgo, t'áá shoodí ba na'alníhí ya sidáhí bich'í naabídíilkíid. Eí doo biigha daago ni ba'nija'go ho'aalagú bich'í hodiilní. Hai'daa íini'taago eíya, t'áá shoodí diné ya atáh halne'ígú ní béesh bee hane'í wólta' bí'ki sí'niilígú bí'kéhgo bich'í hodiilní.

아직 가입하지 않았거나 한국어로 된 도움말이 필요한 경우 영업 관리자나 그룹 관리자에게 문의하시기 바랍니다. 이미 가입한 경우 ID 카드에 있는 번호를 사용하여 고객 서비스에 문의하시기 바랍니다.

Nếu quý vị chưa phải là một hội viên và cần được giúp đỡ bằng Tiếng Việt, xin liên lạc với đại diện thương mại của quý vị hoặc quản trị viên nhóm. Nếu quý vị đã ghi danh, xin liên lạc với dịch vụ khách hàng qua việc dùng số điện thoại ghi trên thẻ ID của quý vị.

—————*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: \$7,050
- Patient pays: \$490

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 | \$340 |
| Coinsurance | \$0 |
| Limits or exclusions | \$150 |
| Total | \$490 |

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

- Amount owed to providers: \$5,400
- Plan pays: \$4,670
- Patient pays: \$730

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 | \$650 |
| Coinsurance | \$0 |
| Limits or exclusions | \$80 |
| Total | \$730 |

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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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