

Anthem Blue Cross County Of San Diego – Anthem PPO Plan (outside CA)

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

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

Coverage for: Individual/Family | Plan Type: PPO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at <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> ?	For PPO Providers: \$300 Member/ \$600 Family For Non-PPO Providers: \$600 Member/ \$1,200 Family Does not apply to Preventive Care, Office Visit Copayments, and Prescription Drugs. PPO Provider and Non-PPO Provider deductibles are combined. Satisfying one helps satisfy the other.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	Yes. \$150 /Admission PPO hospital (waived for emergency admission). \$300 /Admission for Non-PPO hospital (waived for emergency admission). \$500 /Admission for hospital if utilization review not obtained (waived for emergency admission). \$75 /Visit for Emergency Room services (waived if admitted directly from ER).	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. For PPO Providers: \$2,300 Member/Year \$4,600 Family/Year For Non-PPO Providers: \$4,600 Member/Year \$9,200 Family/Year PPO Provider and Non-PPO Provider out-of-pocket are separate and do not count towards each other.	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.

Questions: Call 1-800-227-3771 or visit us at <http://www.anthem.com/ca>.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://www.anthem.com/ca> or call 1-800-227-3771 to request a copy.

What is not included in the <u>out-of-pocket limit</u>?	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 3 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 PPO 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 3 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u>?	No. You don't need a referral to see a specialist.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 8. See your policy or plan document for additional information about <u>excluded services</u> .



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use PPO **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 Copay/Visit	40% Coinsurance	-----none-----
	Specialist visit	\$40 Copay/Visit	40% Coinsurance	-----none-----
	Other practitioner office visit	Chiropractor 20% Coinsurance Acupuncturist 20% Coinsurance	Chiropractor 40% Coinsurance Acupuncturist 40% Coinsurance	Chiropractor Coverage is limited to 24 visits per benefit period. Additional visits may be authorized. Services from In-Network and Non-Network providers count towards your benefit period limit. Chiropractic visits count towards your physical and occupational therapy limit. Acupuncturist Coverage is limited to 12 visits for In-Network and Non-Network providers/per benefit period.
	Preventive care/screening/immunization	No Cost Share	40% Coinsurance	For Non-PPO Providers routine physical exams, immunizations, diagnostic X-ray & lab for routine physical exam (members 7 years old and older) are not covered.
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office 20% Coinsurance X-Ray – Office 20% Coinsurance	Lab – Office 40% Coinsurance X-Ray – Office 40% Coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	40% Coinsurance	Subject to utilization review. Costs may vary by site of service. You should refer to your formal contract of coverage for details.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
<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/searchcriteria?branding=ABC&provtype=Rx</p>	<p>Tier 1 – Typically Generic <i>(includes diabetic supplies)</i></p>	<p>\$10 Copay/ prescription (retail) \$20 Copay/ prescription (home delivery)</p>	<p>\$10 Copay/ prescription plus 50% of the remaining prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowed amount</p>	<p>For Non-Network: Member pays the retail pharmacy copay plus 50%.</p> <p>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.</p>
	<p>Tier 2 – Typically Preferred/ Brand Name Formulary</p>	<p>\$20 Copay/ prescription (retail) \$40 Copay/ prescription (home delivery)</p>	<p>\$20 Copay/ prescription plus 50% of the remaining prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowed amount</p>	<p>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>
	<p>Tier 3 – Typically Non-Preferred/Brand Name Non-Formulary Drugs <i>(includes compound drugs; retail only)</i></p>	<p>\$35 Copay/ prescription (retail) \$60 Copay/ prescription (home delivery)</p>	<p>\$35 Copay/ prescription plus 50% of the remaining prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowed amount</p>	
	<p>Tier 4 – Typically Specialty Drugs <i>(includes self-administered injectable drugs/ except insulin)</i></p>	<p>\$35 Copay/ prescription (retail) \$60 Copay/ prescription (home delivery)</p>	<p>50% Coinsurance</p>	<p>For Non-Network: Member pays the retail pharmacy copay plus 50%.</p> <p>For Non-Participating Pharmacies, compound drugs & certain specialty pharmacy drugs are not covered. Certain specialty drugs must be obtained through the specialty pharmacy program.</p> <p>30-day supply for Specialty Pharmacy.</p>

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	40% Coinsurance	Coverage is limited to \$350/Day for Non-PPO Providers.
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	-----none-----
If you need immediate medical attention	Emergency room services	20% Coinsurance	20% Coinsurance	Additional deductible of \$75 applies, waived if admitted in patient. This is for the hospital/facility charge only. The ER physician charge may be separate.
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	-----none-----
	Urgent care	\$20 Copay/Visit	40% Coinsurance	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)	20% Coinsurance	40% Coinsurance	\$150 /admission deductible applies for PPO hospitals or residential treatment centers; waived for emergency admissions. \$300 /admission deductible applies for Non-PPO hospitals; waived for emergency admissions. Failure to obtain utilization review will result in an additional \$500 deductible for hospitals; waived for emergency admissions. Subject to utilization review for inpatient services; waived for emergency admissions.
	Physician/surgeon fee	20% Coinsurance	40% Coinsurance	-----none-----

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit \$20 Copay/Visit Mental/Behavioral Health Facility Visit – Facility Charges 20% Coinsurance	Mental/Behavioral Health Office Visit 40% Coinsurance Mental/Behavioral Health Facility Visit – Facility Charges 40% Coinsurance	-----none-----
	Mental/Behavioral health inpatient services	20% Coinsurance	40% Coinsurance	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 \$20 Copay/Visit Substance Abuse Facility Visit – Facility Charges 20% Coinsurance	Substance Abuse Office Visit 40% Coinsurance Substance Abuse Facility Visit – Facility Charges 40% Coinsurance	-----none-----
	Substance use disorder inpatient services	20% Coinsurance	40% Coinsurance	This is for facility professional services only. Please refer to your hospital stay for facility fee.
If you are pregnant	Prenatal and postnatal care	20% Coinsurance	40% Coinsurance	-----none-----
	Delivery and all inpatient services	20% Coinsurance	40% Coinsurance	\$150 /admission deductible applies for PPO hospitals or residential treatment centers; waived for emergency admissions. \$300 /admission deductible applies for Non-PPO hospitals; waived for emergency admissions. Failure to obtain utilization review will result in an additional \$500 deductible for hospitals; waived for emergency admissions. Subject to utilization review for inpatient services; waived for emergency admissions.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	40% Coinsurance	Coverage is limited to a total of 100 visits, In-Network Provider and Non-Network Provider combined per benefit period (one visit by a home health aide equals four hours or less; not covered while member receives hospice care). Services from In-Network Provider and Non-Network Provider count towards your limit.
	Rehabilitation services	20% Coinsurance	40% Coinsurance	Coverage is limited to 24 visits combined for Occupational, Physical therapies including Chiropractor services. Additional visits may be authorized. Services from In-Network and Non-Network providers count toward your limit. Costs may vary by site of service. You should refer to your formal contract of coverage for details.
	Habilitation services	20% Coinsurance	40% Coinsurance	All rehabilitation and habilitation visits count toward your rehabilitation visit limit. Costs may vary by site of service. Please refer to your formal contract.
	Skilled nursing care	20% Coinsurance	40% Coinsurance	Subject to utilization review. Coverage is limited to a combined total of 100 days per benefit period for services received from In-Network & Non-Network Providers.
	Durable medical equipment	20% Coinsurance	40% Coinsurance	-----none-----
	Hospice service	20% Coinsurance	20% Coinsurance	-----none-----
	If your child needs dental or eye care	Eye exam	Not Covered	Not Covered
Glasses		Not Covered	Not Covered	-----none-----
Dental check-up		Not Covered	Not Covered	-----none-----

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- 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
- Hearing aids (Coverage is limited to one Hearing aid per ear every three years.)
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide

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.

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.**

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 iínizinigo t'áá diné k'éjíggo, t'áá shoodí ba na'alnihí ya sidáhí bich'j naabídííkiid. Eí doo biigha daago ni ba'nija'go ho'aalagí bich'j hodiilní. Hai'daq iini'taago eíya, t'áá shoodí diné ya atáh halne'ígí ní béesh bee hane'í wólta' bi'ki si'núligí bi'kéhgo bich'j 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.*—————

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays:** \$5,560
- **Patient pays:** \$1,980

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	\$450
Copays	\$20
Coinsurance	\$1,360
Limits or exclusions	\$450
Total	\$1,980

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

- **Amount owed to providers:** \$5,400
- **Plan pays:** \$4,180
- **Patient pays:** \$1,220

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	\$300
Copays	\$600
Coinsurance	\$240
Limits or exclusions	\$80
Total	\$1,220

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.

Questions: Call 1-800-227-3771 or visit us at <http://www.anthem.com/ca>.

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