

Anthem Blue Cross of California

Anthem Silver 70 EPO, a Multi-State Plan

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

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

Coverage for: Individual + Family | Plan Type: EPO



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.anthem.com/ca or by calling (855) 634-3381.

| Important Questions | Answers | Why this Matters: |
|---|--|---|
| What is the overall deductible ? | \$2,000 person / \$4,000 family for In-Network Provider. Does not apply to Prescription Drugs, Preventive Care, Primary Care visit and Specialist visit. | You must pay all costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible 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 deductible . |
| Are there other deductibles for specific services? | Yes; \$250 person / \$500 family for In-Network Provider Tier 2, Tier 3 and Tier 4 Prescription Drugs. There are no other specific deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| Is there an out-of-pocket limit on my expenses? | Yes; \$6,250 person / \$12,500 family for In-Network Provider. | 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, and Health Care This Plan Doesn't Cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit |
| Is there an overall annual limit on what the plan pays? | No; This policy has no overall annual limit on the amount it will pay each year. | 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 network of providers ? | Yes; See www.anthem.com/ca or call (855) 634-3381 for a list of participating providers. | 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 |

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If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call (855) 634-3381 to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|--|
| | | 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 do not 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 **In-Network provider** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost if You Use a Preferred Network Provider | Your Cost if You Use an In-Network Provider | Your Cost if You Use a Non-Network Provider | Limitations & Exceptions |
|---|--|--|--|--|--|
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$45 copay | \$45 copay | Not covered | -----none----- |
| | Specialist visit | \$65 copay | \$65 copay | Not covered | -----none----- |
| | Other practitioner office visit | <u>Chiropractor</u> Not Covered <u>Acupuncturist</u> \$45 copay | <u>Chiropractor</u> Not covered <u>Acupuncturist</u> \$45 copay | <u>Chiropractor</u> Not covered <u>Acupuncturist</u> Not covered | <u>Chiropractor</u> Not covered <u>Acupuncturist</u> -----none----- |
| | Preventive care/screening/immunization | No charge | No charge | Not covered | -----none----- |
| If you have a test | Diagnostic test (x-ray, blood work) | <u>Lab – Office</u> \$45 copay <u>X-Ray – Office</u> \$65 copay | <u>Lab – Office</u> \$45 copay <u>X-Ray – Office</u> \$65 copay | <u>Lab – Office</u> Not covered <u>X-Ray – Office</u> Not covered | <u>Lab – Office</u> -----none----- <u>X-Ray – Office</u> -----none----- |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 20% coinsurance | Not covered | -----none----- |
| If you need drugs to treat your illness or condition | Tier 1 - Typically Generic | \$15 copay per prescription (retail only) and | \$15 copay per prescription (retail only) and | Not covered | Covers up to a 30 day supply (retail pharmacy). |

| Common Medical Event | Services You May Need | Your Cost if You Use a Preferred Network Provider | Your Cost if You Use an In-Network Provider | Your Cost if You Use a Non-Network Provider | Limitations & Exceptions |
|---|--|---|---|---|--|
| <p>More information about prescription drug coverage is available at http://www.anthem.com/pharmacyinformation/</p> | | \$30 copay per prescription (home delivery only) | \$30 copay per prescription (home delivery only) | | Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs. |
| | Tier 2 - Typically Preferred/Formulary Brand | \$50 copay per prescription and then 0% coinsurance (retail only) and \$125 copay per prescription and then 0% coinsurance (home delivery only) | \$50 copay per prescription and then 0% coinsurance (retail only) and \$125 copay per prescription and then 0% coinsurance (home delivery only) | Not covered | Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs. |
| | Tier 3 – Typically Non-Preferred brand drugs | \$70 copay per prescription and then 0% coinsurance (retail only) and \$175 copay per prescription and then 0% coinsurance (home delivery only) | \$70 copay per prescription and then 0% coinsurance (retail only) and \$175 copay per prescription and then 0% coinsurance (home delivery only) | Not covered | Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs. |
| | Tier 4 -Typically Specialty Drugs | 20% coinsurance (retail and home delivery) | 20% coinsurance (retail and home delivery) | Not covered | Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home |

| Common Medical Event | Services You May Need | Your Cost if You Use a Preferred Network Provider | Your Cost if You Use an In-Network Provider | Your Cost if You Use a Non-Network Provider | Limitations & Exceptions |
|--|--|--|--|--|---|
| | | | | | delivery program). No coverage for non-formulary drugs. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 20% coinsurance | Not covered | -----none----- |
| | Physician/surgeon fees | 20% coinsurance | 20% coinsurance | Not covered | -----none----- |
| If you need immediate medical attention | Emergency room services | \$250 copay | \$250 copay | \$250 copay | Copay waived if admitted. |
| | Emergency medical transportation | \$250 copay | \$250 copay | \$250 copay | -----none----- |
| | Urgent care | \$90 copay | \$90 copay | \$90 copay | -----none----- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance | 50% coinsurance | Not covered | -----none----- |
| | Physician/surgeon fee | 20% coinsurance | 20% coinsurance | Not covered | -----none----- |
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | <u>Mental/Behavioral Health Office Visit</u> \$45 copay | <u>Mental/Behavioral Health Office Visit</u> \$45 copay | <u>Mental/Behavioral Health Office Visit</u> Not covered | <u>Mental/Behavioral Health Office Visit</u> -----none----- |
| | | <u>Mental/Behavioral Health Facility Visit-Facility Charges</u> 20% coinsurance | <u>Mental/Behavioral Health Facility Visit-Facility Charges</u> 20% coinsurance | <u>Mental/Behavioral Health Facility Visit-Facility Charges</u> Not covered | <u>Mental/Behavioral Health Facility Visit-Facility Charges</u> -----none----- |
| | Mental/Behavioral health inpatient services | 20% coinsurance | 50% coinsurance | Not covered | -----none----- |

| Common Medical Event | Services You May Need | Your Cost if You Use a Preferred Network Provider | Your Cost if You Use an In-Network Provider | Your Cost if You Use a Non-Network Provider | Limitations & Exceptions |
|----------------------|--|--|--|---|---|
| | | | | | |
| | Substance use disorder outpatient services | <u>Substance Abuse Office Visit</u> \$45 copay <u>Substance Abuse Facility Visit - Facility Charges</u> 20% coinsurance | <u>Substance Abuse Office Visit</u> \$45 copay <u>Substance Abuse Facility Visit - Facility Charges</u> 20% coinsurance | <u>Substance Abuse Office Visit</u> Not covered <u>Substance Abuse Facility Visit - Facility Charges</u> Not covered | <u>Substance Abuse Office Visit</u> -----none----- <u>Substance Abuse Facility Visit - Facility Charges</u> -----none----- |
| | Substance use disorder inpatient services | 20% coinsurance | 50% coinsurance | Not covered | -----none----- |
| If you are pregnant | Prenatal and postnatal care | <u>Prenatal</u> No Charge <u>Postnatal</u> \$45 copay | <u>Prenatal</u> No Charge <u>Postnatal</u> \$45 copay | Not covered | -----none----- |
| | Delivery and all inpatient services | 20% coinsurance | 50% coinsurance | Not covered | Applies to inpatient facility. Other cost shares may apply depending on services provided. |

| Common Medical Event | Services You May Need | Your Cost if You Use a Preferred Network Provider | Your Cost if You Use an In-Network Provider | Your Cost if You Use a Non-Network Provider | Limitations & Exceptions |
|---|---------------------------|---|---|---|--|
| If you need help recovering or have other special health needs | Home health care | 20% coinsurance | 20% coinsurance | Not covered | -----none----- |
| | Rehabilitation services | \$45 copay | \$45 copay | Not covered | -----none----- |
| | Habilitation services | \$45 copay | \$45 copay | Not covered | -----none----- |
| | Skilled nursing care | 20% coinsurance | 20% coinsurance | Not covered | -----none----- |
| | Durable medical equipment | 20% coinsurance | 20% coinsurance | Not covered | -----none----- |
| | Hospice service | No charge | No charge | Not covered | -----none----- |
| If your child needs dental or eye care | Eye exam | No charge | No charge | Not covered | Coverage for In-Network is limited to one exam per year |
| | Glasses | No charge | No charge | Not covered | Coverage for In-Network is limited to 1 unit per year. |
| | Dental check-up | No charge | No charge | Not covered | Coverage for In-Network is limited to one visit every 6 months |

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.)

- Chiropractic care
- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide.
- Private-duty nursing
- Non-Formulary drugs
- Routine eye care (adult)
- Routine foot care
- Termination of pregnancy except in limited circumstances
- 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
- Dental care (pediatric)

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your premium. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at (855) 634-3381. You may also contact your state insurance department at:

MSPP External Review

National HealthCare Operations

U.S. Office of Personnel Management

1900 E. Street, N.W.

Washington, DC 20415

(855) 318-0714

www.opm.gov/healthcare-insurance/multi-state-plan-program/

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:

ATTN: Grievances and Appeals
P.O. Box 4310
Woodland Hills, CA 91365-4310

MSPP External Review
National HealthCare Operations
U.S. Office of Personnel
Management
1900 E. Street, N.W.
Washington, DC 20415
(855) 318-0714
[www.opm.gov/healthcareinsurance/
multi-state-plan-program/](http://www.opm.gov/healthcareinsurance/multi-state-plan-program/)

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.**

Language Access Services:

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。

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoolwol íinízinigo t'áa diné k'éjígoo, t'áa shoodí ba na'alníhí ya sidáhí bich'í naabídíílkíid. Eí doo biigha daago ni ba'nija'go ho'aalagíí bich'í hodiilní. Hai'daa íini'taago eíya, t'áa shoodí diné ya atáh halne'ígú ní béesh bee hane'í wólta' bí'ki si'niilígú bí'kéhgo bí'ch'í hodiilní.

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.

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.

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 \$3,440
- Patient pays \$4,100

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 | \$2,000 |
| Copays | \$400 |
| Coinsurance | \$1,700 |
| Limits or exclusions | \$0 |
| Total | \$4,100 |

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact: www.anthem.com/ca or (855) 634-3381.

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

- Amount owed to providers: \$5,400
- Plan pays \$2,400
- Patient pays \$3,000

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 | \$600 |
| Copays | \$2,100 |
| Coinsurance | \$0 |
| Limits or exclusions | \$300 |
| Total | \$3,000 |

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: www.anthem.com/ca or (855) 634-3381.

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 **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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