

# Anthem Blue Cross of California

## Anthem Bronze 60 PPO (a Tiered PPO Plan)

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

Coverage Period: 01/01/2016 – 12/31/2016  
 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 [www.anthem.com/ca/sbc](http://www.anthem.com/ca/sbc) or by calling (855) 634-3381.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	<b>\$6,000</b> person / <b>\$12,000</b> family for In-Network Providers. Does not apply to Prescription Drugs and Preventive Care. <b>\$12,000</b> person / <b>\$24,000</b> family for Out-of-Network Providers.	You must pay all 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; <b>\$500</b> person / <b>\$1,000</b> family for In-Network Providers Prescription Drugs.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes; <b>\$6,500</b> person / <b>\$13,000</b> family for In-Network Providers. <b>\$18,000</b> person / <b>\$36,000</b> family for Out-of-Network Providers.	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> ?	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, Pathway X – PPO Tiered. For a list of In-Network providers, see	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

Questions: Call (855) 634-3381 or visit us at [www.anthem.com/ca](http://www.anthem.com/ca)

CA/I/F/Anthem Bronze 60 PPO (a Tiered PPO Plan)/ 1X5G/NA/01-16

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](http://www.cciio.cms.gov) or call (855) 634-3381 to request a copy.

Important Questions	Answers	Why this Matters:
	<a href="http://www.anthem.com/ca">www.anthem.com/ca</a> or call (855) 634-3381. Dental and Vision benefits may access a different network of providers.	out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 3 for how this plan pays different kinds of <b>providers</b> .
<b>Do I need a referral to see a <u>specialist</u>?</b>	No; You do not need a referral to see a specialist.	You can see the <b>specialist</b> you choose without permission from this plan.
<b>Are there services this plan doesn't cover?</b>	Yes.	Some of the services this plan doesn't cover are listed on page 11. See your policy or plan document for additional information about <b>excluded services</b> .



- **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 a Preferred Network Hospital Provider	Your Cost if You Use an In-Network I Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care <u>provider's office or clinic</u>	Primary care visit to treat an injury or illness	Not Applicable	\$70 copay per	60% coinsurance after deductible	In Network Deductible is waived for the first 3 visits combined for the following benefits: Primary Care Physician (PCP), Specialty Care Provider (SCP), other practitioner, retail health clinic, online care, Telehealth or acupuncture Office Visits; outpatient Behavioral Health Treatment for Pervasive Developmental

Common Medical Event	Services You May Need	Your Cost if You Use a Preferred Network Hospital Provider	Your Cost if You Use an In-Network I Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
					Disorder or autism services; maternity postnatal care; outpatient Mental Health and Substance Abuse services or urgent care visits
	Specialist visit	Not Applicable	\$90 copay per visit	60% coinsurance after deductible	-----none-----
	Other practitioner office visit	Not Applicable	\$70 copay per visit	60% coinsurance after deductible	Deductible applies after first 3 non-preventive visits.
	Preventive care/screening/immunization	Not Applicable	No charge	60% coinsurance after deductible	-----none-----
If you have a test	Diagnostic test (x-ray, blood work)	<u>Lab – Office</u> Not Applicable <u>X-Ray – Office</u> Not Applicable	<u>Lab – Office</u> \$40 copay medical deductible does not apply <u>X-Ray – Office</u> 100% coinsurance after medical deductible	<u>Lab – Office</u> 60% coinsurance after deductible <u>X-Ray – Office</u> 60% coinsurance after deductible	<u>Lab – Office</u> -----none----- <u>X-Ray – Office</u> -----none-----
	Imaging (CT/PET scans, MRIs)	Not Applicable	100% coinsurance after medical	60% coinsurance after deductible	-----none-----

Common Medical Event	Services You May Need	Your Cost if You Use a Preferred Network Hospital Provider	Your Cost if You Use an In-Network I Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
<p><b>If you need drugs to treat your illness or condition</b>            More information about <b>prescription drug coverage</b> is available at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a>             Anthem Select Drug List</p>	Tier 1 - Typically Generic	Not Applicable	deductible  100% coinsurance up to \$500 after pharmacy deductible (retail only) 100% coinsurance up to \$1,500 after pharmacy deductible (home delivery only)	60% coinsurance after deductible	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 2 - Typically Preferred/Formulary Brand	Not Applicable	100% coinsurance up to \$500 after pharmacy deductible (retail only)  100% coinsurance up to \$1,500 (home delivery only)	60% coinsurance after deductible	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/Non-formulary and Specialty Drugs	Not Applicable	100% coinsurance up to \$500 after pharmacy deductible (retail only)  100% coinsurance up to \$1,500 after pharmacy deductible	60% coinsurance after deductible	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.

Common Medical Event	Services You May Need	Your Cost if You Use a Preferred Network Hospital Provider	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
			(home delivery only)		
	Tier 4 - Typically Specialty Drugs	Not Applicable	100% coinsurance up to \$500 (retail only) and 100% coinsurance up to \$1,500 after pharmacy deductible (home delivery only)	Not covered	Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program). No coverage for non-formulary drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Applicable	100% coinsurance after medical deductible	60% coinsurance after deductible	-----none-----
	Physician/surgeon fees	Not Applicable	100% coinsurance after medical deductible	60% coinsurance after deductible	-----none-----
If you need immediate medical attention	Emergency room services	<u>Emergency Room Facility Charge</u> 100% coinsurance after medical deductible	<u>Emergency Room Facility Charge</u> 100% coinsurance after medical deductible	<u>Emergency Room Facility Charge</u> Covered as In-Network	<u>Emergency Room Facility Charge</u> -----none-----
		<u>Emergency Room Physician Fee</u> Not Applicable	<u>Emergency Room Physician Fee</u> 100% coinsurance after medical deductible	<u>Emergency Room Physician Fee</u> Covered as In-Network	<u>Emergency Room Physician Fee</u> -----none-----
	Emergency medical transportation	Not Applicable	100% coinsurance after medical deductible	Covered as In-Network	-----none-----

Common Medical Event	Services You May Need	Your Cost if You Use a Preferred Network Hospital Provider	Your Cost if You Use an In-Network I Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
	Urgent care	Not Applicable	\$120 copay per visit	Covered as In-Network	Deductible applies after first 3 non-preventive visits.
If you have a hospital stay	Facility fee (e.g., hospital room)	100% coinsurance after medical deductible	100% coinsurance after medical deductible	60% coinsurance after deductible	-----none-----
	Physician/surgeon fee	Not Applicable	100% coinsurance after deductible	60% coinsurance after deductible	-----none-----
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	<u>Mental/Behavioral Health Office Visit</u> Not Applicable  <u>Mental/Behavioral Health Other Outpatient Items and Services</u> \$70 copay per visit	<u>Mental/Behavioral Health Office Visit</u> \$70 copay per visit <u>Mental/Behavioral Health Other Outpatient Items and Services</u> \$70 copay per visit	<u>Mental/Behavioral Health Office Visit</u> 60% coinsurance after deductible <u>Mental/Behavioral Health Other Outpatient Items and Services</u> 60% coinsurance after deductible	<u>Mental/Behavioral Health Office Visit</u> Deductible applies after first 3 non-preventive visits. <u>Mental/Behavioral Health Other Outpatient Items and Services</u> ----- -none-----
	Mental/Behavioral health inpatient services	<u>Inpatient Facility Fee</u> 100% coinsurance after medical deductible  <u>Inpatient Physician Fees</u> Not Applicable	<u>Inpatient Facility Fee</u> 100% coinsurance after medical deductible  <u>Inpatient Physician Fees</u> 100% coinsurance after medical deductible	<u>Inpatient Facility Fee</u> 60% coinsurance after deductible  <u>Inpatient Physician Fees</u> 60% coinsurance after medical deductible	<u>Inpatient Facility Fee</u> -----none----- <u>Inpatient Physician Fees</u> -----none-----

Common Medical Event	Services You May Need	Your Cost if You Use a Preferred Network Hospital Provider	Your Cost if You Use an In-Network I Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
	Substance use disorder outpatient services	<u>Substance Use Disorder Office Visit</u> Not Applicable  <u>Substance Use Disorder Other Outpatient Items and Services</u> \$70 copay per visit	<u>Substance Use Disorder Office Visit</u> \$70 copay per visit  <u>Substance Use Disorder Other Outpatient Items and Services</u> \$70 copay per visit	<u>Substance Use Disorder Office Visit</u> 60% coinsurance after deductible  <u>Substance Use Disorder Other Outpatient Items and Services</u> 60% coinsurance after deductible	<u>Substance Use Disorder Office Visit</u> Deductible applies after first 3 non-preventive visits.  <u>Substance Use Disorder Other Outpatient Items and Services</u> -----none-----
	Substance use disorder inpatient services	<u>Inpatient Facility Fee</u> 100% coinsurance after medical deductible  <u>Inpatient Physician Fees</u> Not Applicable	<u>Inpatient Facility Fee</u> 100% coinsurance after medical deductible  <u>Inpatient Physician Fee</u> 100% coinsurance after medical deductible	<u>Inpatient Facility Fee</u> 60% coinsurance after deductible  <u>Inpatient Physician Fee</u> 60% coinsurance after medical deductible	<u>Inpatient Facility Fee</u> -----none-----  <u>Inpatient Physician Fees</u> -----none-----
If you are pregnant	Prenatal and postnatal care	Not Applicable	100% coinsurance after medical deductible	60% coinsurance after deductible	In-Network preventative prenatal and postnatal services are covered at 100%.



Common Medical Event	Services You May Need	Your Cost if You Use a Preferred Network Hospital Provider	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
	Delivery and all inpatient services	<u>Inpatient Facility Fee</u> 100% coinsurance after medical deductible  <u>Inpatient Physician Fees</u> Not Applicable	<u>Inpatient Facility Fee</u> 100% coinsurance after medical deductible  <u>Inpatient Physician Fees</u> 100% coinsurance after medical deductible	<u>Inpatient Facility Fee</u> 60% coinsurance after deductible  <u>Inpatient Physician Fees</u> 100% coinsurance after medical deductible	<u>Inpatient Facility Fee</u> -----none-----  <u>Inpatient Physician Fees</u> -----none-----
If you need help recovering or have other special health needs	Home health care	Not Applicable	100% coinsurance after medical deductible	60% coinsurance after deductible	Coverage for Non-Network Providers is limited to 100 visits per benefit period.
	Rehabilitation services	Not Applicable	\$70 copay per visit	60% coinsurance after deductible	Deductible applies after first 3 non-preventive visits
	Habilitation services	Not Applicable	\$70 copay per visit	60% coinsurance after deductible	-----none-----
	Skilled nursing care	100% coinsurance after medical deductible	100% coinsurance after medical deductible	60% coinsurance after deductible	Coverage for Non-Network Providers is limited to 100 days per benefit period.
	Durable medical	Not Applicable	100% coinsurance	60% coinsurance	-----none-----

Common Medical Event	Services You May Need	Your Cost if You Use a Preferred Network Hospital Provider	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
	equipment		after medical deductible	after deductible	
	Hospice service	Not Applicable	No charge	60% coinsurance after deductible	-----none-----
<b>If your child needs dental or eye care</b>	Eye exam	Not Applicable	No charge	No charge	Coverage for In-Network Providers and Non-Network Providers combined is limited to 1 exam per benefit period.
	Glasses	Not Applicable	No charge	No charge	Coverage for In-Network Providers and Non-Network Providers combined is limited to 1 unit per benefit period.
	Dental check-up	Not Applicable	No charge	No charge	-----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.)

- 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](http://www.bcbs.com/bluecardworldwide).
- Private-duty nursing
- Non-Formulary drugs
- Routine eye care (Adult)
- Routine foot care
- 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 Deductible applies after first 3 non-preventive visits..
- Bariatric surgery

## 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:

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

## 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

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

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](mailto: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.**

## 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 íínízínigo t'áá diné k'éjígoo, t'áá 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'áá shoodí diné ya atáh halne'ígú ní béesh bee hane'í wólta' bí'ki sí'niilígú bí'kéhgo bich'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.

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*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 \$1,298
- Patient pays \$6,242

#### 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
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$6,137
Copays	\$105
Coinsurance	\$0
Limits or exclusions	\$0
<b>Total</b>	<b>\$6,242</b>

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

- Amount owed to providers: \$5,400
- Plan pays \$4,053
- Patient pays \$1,347

#### 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
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$872
Copays	\$175
Coinsurance	\$0
Limits or exclusions	\$300
<b>Total</b>	<b>\$1,347</b>

# 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.

**Questions:** Call (855) 634-3381 or visit us at [www.anthem.com/ca](http://www.anthem.com/ca)

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