

# Anthem Blue Cross: Anthem Catastrophic Direct Access

Coverage Period: 01/01/2014 – 12/31/2014

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 [www.anthem.com/ca](http://www.anthem.com/ca) or by calling 1-855-333-5730.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	<b>\$6,350</b> person/ <b>\$12,700</b> family Does not apply to preventive care, office visits, diagnostic tests, prescription drugs, and other services as referenced in the member contract.	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 2 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. For non-participating providers <b>\$12,700</b> person / <b>\$25,400</b> family for medical services.	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 participating providers <b>\$6,350</b> person / <b>\$12,700</b> family. For non-participating providers <b>\$19,050</b> person / <b>\$38,100</b> 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> ?	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 <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> or call 1-855-333-5730 for a list of participating 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> .

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<p><b>Do I need a referral to see a <u>specialist</u>?</b></p>	<p>Yes, you need written approval to see a specialist. There may be some providers or services for which referrals are not required. Please see the formal contract of coverage for details.</p>	<p>This plan will pay some or all of the costs to see a <b>specialist</b> for covered services but only if you have the plan's permission before you see the <b>specialist</b>.</p>
<p><b>Are there services this plan doesn't cover?</b></p>	<p>Yes.</p>	<p>Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about <b>excluded services</b>.</p>



- **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 participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
<p>If you visit a health care <u>provider's</u> office or clinic</p>	<p>Primary care visit to treat an injury or illness</p>	<p>No charge for first 3 visits; after 3 visits, 0% after deductible</p>	<p>30% coinsurance after deductible</p>	<p>_____none_____</p>
	<p>Specialist visit</p>	<p>0% coinsurance after deductible</p>	<p>30% coinsurance after deductible</p>	<p>_____none_____</p>

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	Other practitioner office visit	0% coinsurance after deductible	30% coinsurance after deductible	_____none_____
	Preventive care/screening/immunization	No charge	30% coinsurance after deductible	_____none_____
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	0% coinsurance after deductible	30% coinsurance after deductible	_____none_____
	Imaging (CT/PET scans, MRIs)	0% coinsurance after deductible	30% coinsurance after deductible	_____none_____
<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">www.anthem.com/pharmacyinformation</a> .	Tier 1 drugs	0% coinsurance after deductible	30% coinsurance after deductible	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Tier 2 drugs	0% coinsurance after deductible	30% coinsurance after deductible	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Tier 3 drugs	0% coinsurance after deductible	30% coinsurance after deductible	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Tier 4 drugs	0% coinsurance after deductible	30% coinsurance after deductible	Classified specialty drugs must be obtained through our Specialty Pharmacy Program and are subject to the terms of the program.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	0% coinsurance after deductible	30% coinsurance after deductible	_____none_____

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	Physician/surgeon fees	0% coinsurance after deductible	30% coinsurance after deductible	_____none_____
<b>If you need immediate medical attention</b>	Emergency room services	0% coinsurance after deductible	0% coinsurance after deductible	_____none_____
	Emergency medical transportation	0% coinsurance after deductible	0% coinsurance after deductible	_____none_____
	Urgent care	No charge for first 3 visits; after 3 visits, 0% after deductible	0% coinsurance after deductible	Costs may vary by site of service. You should refer to your formal contract of coverage for details.
<b>aIf you have a hospital stay</b>	Facility fee (e.g., hospital room)	0% coinsurance after deductible	30% coinsurance after deductible	_____none_____
	Physician/surgeon fee	0% coinsurance after deductible	30% coinsurance after deductible	_____none_____

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Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	No charge for first 3 visits; after 3 visits, 0% after deductible	30% coinsurance after deductible	_____none_____
	Mental/Behavioral health inpatient services	0% coinsurance after deductible	30% coinsurance after deductible	_____none_____
	Substance use disorder outpatient services	No charge for first 3 visits; after 3 visits, 0% after deductible	30% coinsurance after deductible	_____none_____
	Substance use disorder inpatient services	0% coinsurance after deductible	30% coinsurance after deductible	_____none_____
<b>If you are pregnant</b>	Prenatal and postnatal care	No charge for prenatal care; 0% coinsurance after deductible for postnatal care	30% coinsurance after deductible	_____none_____
	Delivery and all inpatient services	0% coinsurance after deductible	30% coinsurance after deductible	_____none_____

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<b>If you need help recovering or have other special health needs</b>	Home health care	0% coinsurance after deductible	30% coinsurance after deductible	100 visits per year.
	Rehabilitation services	0% coinsurance after deductible	30% coinsurance after deductible	—————none—————
	Habilitation services	0% coinsurance after deductible	30% coinsurance after deductible	—————none—————
	Skilled nursing care	0% coinsurance after deductible	30% coinsurance after deductible	100 day visit per year.
	Durable medical equipment	0% coinsurance after deductible	30% coinsurance after deductible	—————none—————
	Hospice service	0% coinsurance after deductible	30% coinsurance after deductible	—————none—————
<b>If your child needs dental or eye care</b>	Eye exam	No charge	All charges except \$30 reimbursement	Limited to one exam per year.
	Glasses	No copay for frames and lenses	All charges except specified reimbursement.	Limited to one pair of glasses per year. Non-participating reimbursement may vary by service. You should refer to your formal contract of coverage for details.
	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.)

- Chiropractic care
- Cosmetic surgery
- Dental care
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (except covered under home health benefit)
- 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 (for the treatment of nausea or as part of a comprehensive pain management program for treatment of chronic pain)
- Allergy testing
- Bariatric surgery

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## 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 1-855-333-5730. You may also contact your state insurance department at 1-877-267-2323 x61565.

## 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:

Grievances and Appeals  
P.O. Box 60007  
Los Angeles, CA 90060-0007

Additionally, a consumer assistance program can help you file your appeal. Contact:

Department of Managed Health Care  
California Help Center

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980 9th Street, Suite 500  
Sacramento, CA 95814-2725  
1-888-HMO-2219

## 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:

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'í, shikáa adoolwoł íinízinigo t'áá diné k'éjúgo, t'áá shoodí ba na'alníhí ya sidáhí bich'í naabídíłkiid. Eí doo biigha daago ni ba'nija'go ho'aalagí bich'í hodiilní. Hai'daa iini'taago eíya, t'áá shoodí diné ya atáh halne'ígí ní béesh bee hane'í wólta' bíki si'niilígí bí'kéhgo bich'í hodiilní.

—————*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 \$2,190
- Patient pays \$5,350

#### 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	\$5,200
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$5,350</b>

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

- Amount owed to providers: \$5,400
- Plan pays \$1,060
- Patient pays \$4,340

#### 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	\$4,260
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$4,340</b>

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: 1-855-333-5730.

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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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