

# Marine Corps Community/NAF Employees: Value HMO 20/30/20% on Select Plus Network

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

Coverage Period: 01/01/2013 – 01/01/2014

Coverage for: Individual/Family | 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 [www.anthem.com/ca](http://www.anthem.com/ca) or by calling 1-800-888-8288.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	<b>\$0</b>	See the chart 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 <u>deductibles</u> 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?	<b>\$3,500</b> individual / <b>\$7,000</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. Infertility Services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . The following copay does not apply to the annual copay maximum: for infertility services.
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. For a list of <u>in-area providers</u> , see <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> or call 1-800-888-8288	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> .
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about <u>excluded services</u> .

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- **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**.

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</u> office or clinic	Primary care visit to treat an injury or illness	\$20 copay/visit	Not Covered	
	Specialist visit	\$30 copay/visit	Not Covered	
	Other practitioner office visit	\$20 copay/visit for chiropractor or acupuncture	Not Covered	Chiropractic care limited to a 60 day period of care.
	Preventive care/screening/immunization	No Charge	Not Covered	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance if performed in a hospital or any facility affiliated with a hospital. No copay if performed in a non-hospital setting.	Not Covered	
	Imaging (CT/PET scans, MRIs)	20% coinsurance if performed in a hospital or any facility affiliated with a hospital. \$100/ test if performed in a non-hospital setting.	Not Covered	

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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
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <u>prescription drug coverage</u> is available at <a href="http://www.anthem.com/ca">www.anthem.com/ca</a></p>	Tier 1 drugs (includes diabetic supplies)	\$10 copay/ prescription (retail and home delivery)	<p>Member pays the full retail price of the prescription drug and submits claim form to us for reimbursement. We will reimburse 50% of the remaining prescription drug maximum allowed amount less any pharmacy deductible (if applicable), the above retail pharmacy copay &amp; costs in excess of the prescription drug maximum allowed amount.</p>	<p>Retail pharmacy limited to 30 day supply; home delivery limited to 90 day supply. Maximum \$300 copay/fill. Tier 4 prescription drug coinsurance will accrue to a maximum of \$3,500 per member per year. Once the member has satisfied the \$3,500 maximum, no additional coinsurance will be required for the remainder of the year. The pharmacy deductible does not accumulate towards this out of pocket maximum.</p>
	Tier 2 drugs	\$30 copay/ prescription (retail) \$60 copay/ prescription (home delivery)		
	Tier 3 drugs	\$45 copay/ prescription (retail) \$90 copay/ prescription (home delivery)		
	Tier 4 drugs	20% of prescription drug maximum allowed amount ( maximum \$150 copay per fill for Retail Participating Pharmacy and maximum of \$300 copay per fill for Home Delivery Program)		
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not Covered	
	Physician/surgeon fees	No Copay	Not Covered	

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If you need immediate medical attention	Emergency room services	\$200 copay/visit	\$200 copay/visit	Copay waived if admitted inpatient
	Emergency medical transportation	\$100 copay/trip	\$100 copay/trip (balance billing may apply)	
	Urgent care	\$30 copay/visit	Not Covered	Copay waived if admitted inpatient and outpatient ER.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not Covered	
	Physician/surgeon fee	No Copay	Not Covered	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$20 copay/visit	Not Covered	Pre-service review required.
	Mental/Behavioral health inpatient services	20% coinsurance	Not Covered	
	Substance use disorder outpatient services	\$20 copay/visit	Not Covered	Pre-service review required.
	Substance use disorder inpatient services	20% coinsurance	Not Covered	
If you are pregnant	Prenatal and postnatal care	\$20 copay/visit	Not Covered	
	Delivery and all inpatient services	20% coinsurance	Not Covered	
If you need help recovering or have other special health needs	Home health care	\$20 copay/visit	Not Covered	Limited to 100 visits/calendar year; one visit by a home health aide equals four hours or less.
	Rehabilitation services	20% coinsurance if performed in a hospital or any facility affiliated with a hospital. \$20/visit if performed in a non-hospital setting.	Not Covered	Physical, occupational, or speech therapy is limited to a 60-day period of care. Acupuncture: \$20/visit

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	Habilitation services	20% coinsurance if performed in a hospital or any facility affiliated with a hospital. \$20/visit if performed in a non-hospital setting.	Not Covered	All rehabilitation and habilitation visits count toward your rehabilitation visit limit.
	Skilled nursing care	20% coinsurance	Not Covered	Limited to 100 days/calendar year.
	Durable medical equipment	50% coinsurance	Not Covered	
	Hospice service	No Charge	Not Covered	
<b>If your child needs dental or eye care</b>	Eye exam	Not Covered	Not Covered	
	Glasses	Not Covered	Not Covered	
	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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care
- 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
- Chiropractic care
- Coverage provided outside the United States. See [www.BCBS.com/bluecardworldwide](http://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 1-800-888-8288. 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](http://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](http://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  
Grievance and Appeal Management  
P.O. Box 4310  
Woodland Hills, CA 91367

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

California Department of Insurance  
300 South Spring St.  
Los Angeles, CA 90013  
1-800-927-4357  
[www.insurance.ca.gov](http://www.insurance.ca.gov)

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

California Department of Managed Care  
California Help Center  
980 9<sup>th</sup> St., Suite 500  
Sacramento, CA 95814-2725  
1-888-466-2219  
[www.dmhc.ca.gov](http://www.dmhc.ca.gov)  
[www.healthhelp.ca.gov](http://www.healthhelp.ca.gov)  
[helpline@dmhc.ca.gov](mailto:helpline@dmhc.ca.gov)

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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'í, shikáa adoolwoł iínizinigo t'áá diné k'éjígoo, t'áá shoodí ba na'ałníhí ya sidáhí bich'í naabídíłkíid. Eí doo biigha daago ni ba'nija'go ho'aalagú bich'í hodiilní. Hai'daq iini'taago eíya, t'áá shoodí diné ya atáh halne'ígú ní béesh bee hane'í wólta' bi'ki si'núilígú bi'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 \$6,320
- Patient pays \$1,220

#### 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	\$0
Copays	\$40
Coinsurance	\$1,030
Limits or exclusions	\$150
<b>Total</b>	<b>\$1,220</b>

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

- Amount owed to providers: \$5,400
- Plan pays \$4,050
- Patient pays \$1,350

#### 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	\$0
Copays	\$400
Coinsurance	\$870
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,350</b>

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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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