

# Anthem Blue Cross

## Los Angeles Police Relief Association (LAPRA) HMO Actives & Retirees + Preferred HMO (CaliforniaCare Plus) Plan A

Coverage Period: 07/01/2016 – 06/30/2017

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

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 <https://eoc.anthem.com/eocdps/ca/fi> or by calling 1-800-289-2250.

| Important Questions                                      | Answers   | Why this Matters:   |
|--|---|---|
| What is the overall deductible?                          | <b>\$0.</b>   | See the chart starting on page 2 for your costs for services this plan covers.  |
| Are there other deductibles for specific services?       | Yes. <b>\$100</b> Individual/Maximum of three Deductibles for each Family for Outpatient PPO and Non-PPO Providers.   | You must pay all of the costs for these services up to the specific <b>deductible</b> amount before this plan begins to pay for these services.   |
| Is there an <u>out-of-pocket limit</u> on my expenses?   | Yes. <b>\$1,000</b> Individual/ <b>\$3,000</b> Family for In-Network PPO Providers.   | The <b>out-of-pocket limit</b> 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> ? | Infertility Services Copay, Premiums, Balance-billed charges and Health care this plan doesn't cover.   | Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .  |
| Is there an overall annual limit on what the plan pays?  | Yes. For Outpatient PPO Supplement Benefit: <b>\$1,000</b> in plan payments for covered expense.  | 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 1-800-289-2250 for a list of In-Network Providers.  | If you use an in-network doctor or other health care <b>provider</b> , 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 <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 2 for how this plan pays different kinds of <b>providers</b> . |
| Do I need a referral to see a <u>specialist</u> ?        | 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. | 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> .   |
| Are there services this plan doesn't cover?              | Yes.  | 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> .   |

**Questions:** Call 1-800-289-2250 or visit us at [www.anthem.com/ca](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 [www.ccio.cms.gov](http://www.ccio.cms.gov) or call 1-800-289-2250 to request a copy.



- **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 an In-Network HMO Provider                       | Your Cost If You Use an In-Network PPO Provider                      | Limitations & Exceptions   |
|--|--|---|--|--|
| <b>If you visit a health care <u>provider's</u> office or clinic</b> | Primary care visit to treat an injury or illness | \$15 Copay/Visit  | 20% Coinsurance  | Without a referral <b>40%</b> Coinsurance for Non-PPO Providers. The PPO Plus plan maximum payment is <b>\$1,000</b> .   |
|  | Specialist visit                                 | \$15 Copay/Visit  | 20% Coinsurance  | Without a referral <b>40%</b> Coinsurance for Non-PPO Providers. The PPO Plus plan maximum payment is <b>\$1,000</b> .   |
|  | Other practitioner office visit                  | Chiropractor<br>\$15 Copay/Visit<br>Acupuncturist<br>\$15 Copay/Visit | Chiropractor<br>20% Coinsurance<br>Acupuncturist<br>20% Coinsurance  | Chiropractor<br>HMO Provider: Coverage is limited to a 60-day period of care for Physical, Occupational or Speech Therapy or Chiropractic care; additional visits available when approved by the medical group.<br>PPO Provider: Coverage is limited to 12 visits per Benefit Period including Physical Therapy, Physical Medicine and Occupational Therapy.<br>Without a referral <b>40%</b> Coinsurance for Non-PPO Providers. The PPO Plus plan maximum payment is <b>\$1,000</b> . |
|  | Preventive care/screening/immunization           | No Cost Share   | Not Covered  | -----none-----   |
| <b>If you have a test</b>  | Diagnostic test (x-ray, blood work)              | Lab - Office<br>No Cost Share<br>X-Ray - Office<br>No Cost Share      | Lab - Office<br>20% Coinsurance<br>X-Ray - Office<br>20% Coinsurance | Without a referral <b>40%</b> Coinsurance for Non-PPO Providers. The PPO Plus plan maximum payment is <b>\$1,000</b> .   |

| Common Medical Event   | Services You May Need        | Your Cost If You Use an In-Network HMO Provider  | Your Cost If You Use an In-Network PPO Provider   | Limitations & Exceptions   |
|--|------------------------------|--|---|--|
|  | Imaging (CT/PET scans, MRIs) | No Cost Share  | 20% Coinsurance   | Costs may vary by site of service. You should refer to your formal contract of coverage for details. Without a referral <b>40%</b> Coinsurance for Non-PPO Providers. The PPO Plus plan maximum payment is <b>\$1,000</b> .  |
| <p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <b>prescription drug coverage</b> is available at <a href="https://www.anthem.com/ca/health-insurance/provider-directory/searchcriteria?branding=ABC&amp;provtype=Rx">https://www.anthem.com/ca/health-insurance/provider-directory/searchcriteria?branding=ABC&amp;provtype=Rx</a></p> | Generic Drugs                | <b>\$15</b><br>Copay/Prescription for Retail Pharmacy<br><b>\$30</b><br>Copay/Prescription for Home Delivery | <b>\$15</b><br>Copay/Prescription plus <b>50%</b> of the maximum amount allowed and costs in excess of the maximum amount | 30-day supply; (90 days for Maintenance Drugs) 60-day supply for federally Schedule II attention deficit disorder Drugs that require a triplicate Prescription form, but require a double Copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction Drugs (available only at Retail Pharmacies); 90-day supply for Maintenance Drugs, but double Copay is required (Retail Pharmacies). 90-day supply for Home Delivery. |
|  | Brand Name Drugs             | <b>\$25</b><br>Copay/Prescription for Retail Pharmacy<br><b>\$50</b><br>Copay/Prescription for Home Delivery | <b>\$25</b><br>Copay/Prescription plus <b>50%</b> of the maximum amount allowed and costs in excess of the maximum amount | 30-day supply; (90 days for Maintenance Drugs) 60-day supply for federally Schedule II attention deficit disorder Drugs that require a triplicate Prescription form, but require a double Copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction Drugs (available only at Retail Pharmacies); 90-day supply for Maintenance Drugs, but double Copay is required (Retail Pharmacies). 90-day supply for Home Delivery. |
|  | Non-Brand Name Drugs         | <b>\$25</b><br>Copay/Prescription for Retail Pharmacy<br><b>\$50</b><br>Copay/Prescription for Home Delivery | <b>\$25</b><br>Copay/Prescription plus <b>50%</b> of the maximum amount allowed and costs in excess of the maximum amount | 30-day supply; (90 days for Maintenance Drugs) 60-day supply for federally Schedule II attention deficit disorder Drugs that require a triplicate Prescription form, but require a double Copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction Drugs (available only at Retail Pharmacies); 90-day supply for Maintenance Drugs, but double Copay is required (Retail Pharmacies). 90-day supply for Home Delivery. |

| Common Medical Event                    | Services You May Need                              | Your Cost If You Use an In-Network HMO Provider  | Your Cost If You Use an In-Network PPO Provider   | Limitations & Exceptions  |
|---|--|--|---|---|
|   | Self-Administered Injectable Drugs, except Insulin | 20% Coinsurance of Prescription Drug covered expense to a maximum <b>\$150</b> Copay for a 30 day supply at a Retail Pharmacy<br>20% Coinsurance of Prescription Drug covered expense to a maximum <b>\$300</b> Copay for 60-90 day supply for Home Delivery | 20% Coinsurance of Prescription Drug covered expense to a maximum of <b>\$150</b> Copay plus <b>50%</b> of the maximum amount allowed and costs in excess of the maximum amount | -----none-----  |
| If you have outpatient surgery          | Facility fee (e.g., ambulatory surgery center)     | No Cost Share  | 20% Coinsurance   | Without a referral <b>40%</b> Coinsurance for Non-PPO Providers. The PPO Plus plan maximum payment is <b>\$1,000</b> .  |
|   | Physician/surgeon fees                             | No Cost Share  | 20% Coinsurance   | Without a referral <b>40%</b> Coinsurance for Non-PPO Providers. The PPO Plus plan maximum payment is <b>\$1,000</b> .  |
| If you need immediate medical attention | Emergency room services                            | <b>\$150</b> Copay/Visit   | Covered as HMO  | This is for the hospital/facility charge only. The ER physician charge may be separate; copay waived if admitted. In Area (within 20 miles of medical group) and Out of Area. |
|   | Emergency medical transportation                   | No Cost Share  | Covered as HMO  | -----none-----  |
|   | Urgent care  | <b>\$15</b> Copay/Visit  | Covered as HMO  | There may be other levels of cost share that are contingent on how services are provided, please see your formal contract of coverage for a complete explanation.             |
| If you have a hospital stay             | Facility fee (e.g., hospital room)                 | No Cost Share  | Not Covered   | -----none-----  |
|   | Physician/surgeon fee                              | No Cost Share  | Not Covered   | -----none-----  |

| Common Medical Event  | Services You May Need                        | Your Cost If You Use an In-Network HMO Provider   | Your Cost If You Use an In-Network PPO Provider   | Limitations & Exceptions  |
|---|--|---|---|---|
| <b>If you have mental health, behavioral health, or substance abuse needs</b> | Mental/Behavioral health outpatient services | Mental/Behavioral Health Office Visit<br><b>\$15</b> Copay/Visit<br>Mental/Behavioral Health Facility Visit - Facility Charges<br>No Cost Share | Mental/Behavioral Health Office Visit<br>Not Covered<br>Mental/Behavioral Health Facility Visit - Facility Charges<br>Not Covered | -----none-----  |
|   | Mental/Behavioral health inpatient services  | No Cost Share   | Not Covered   | 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<br><b>\$15</b> Copay/Visit<br>Substance Abuse Facility Visit - Facility Charges<br>No Cost Share                   | Substance Abuse Office Visit<br>Not Covered<br>Substance Abuse Facility Visit - Facility Charges<br>Not Covered                   | -----none-----  |
|   | Substance use disorder inpatient services    | No Cost Share   | Not Covered   | This is for facility professional services only. Please refer to your hospital stay for facility fee.   |
| <b>If you are pregnant</b>  | Prenatal and postnatal care                  | <b>\$15</b> Copay/Visit   | Not Covered   | Copay applies for initial visit only. There may be other levels of cost share that are contingent on how services are provided, please see your formal contract of coverage for a complete explanation. |
|   | Delivery and all inpatient services          | No Cost Share   | Not Covered   | -----none-----  |

| Common Medical Event  | Services You May Need                         | Your Cost If You Use an In-Network HMO Provider | Your Cost If You Use an In-Network PPO Provider | Limitations & Exceptions   |
|---|---|---|---|--|
| <b>If you need help recovering or have other special health needs</b> | Home health care                              | \$15 Copay/Visit                                | Not Covered                                     | One visit by a Home health aide equals four hours or less.   |
|   | Rehabilitation services                       | \$15 Copay/Visit                                | 20% Coinsurance                                 | HMO Provider: Coverage is limited to a 60-day period of care for Physical, Occupational or Speech Therapy or Chiropractic care; additional visits available when approved by the medical group.<br>PPO Provider: Coverage is limited to 12 visits per Benefit Period for Physical Therapy, Physical Medicine and Occupational Therapy including Chiropractic services. Costs may vary by site of service. You should refer to your formal contract of coverage for details.<br>Without a referral 40% Coinsurance for Non-PPO Providers. The PPO Plus plan maximum payment is <b>\$1,000</b> . |
|   | Habilitation services                         | \$15 Copay/Visit                                | 20% Coinsurance                                 | Habilitation visits count towards your Rehabilitation limit. Costs may vary by site of service. You should refer to your formal contract of coverage for details. Without a referral 40% Coinsurance for Non-PPO Providers. The PPO Plus plan maximum payment is <b>\$1,000</b> .  |
|   | Skilled nursing care                          | No Cost Share                                   | Not Covered                                     | Coverage is limited to 100 days per Benefit Period.  |
|   | Durable medical equipment                     | No Cost Share                                   | Not Covered                                     | -----none-----   |
|   | Hospice service                               | No Cost Share                                   | Not Covered                                     | -----none-----   |
|   | <b>If your child needs dental or eye care</b> | 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
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (Unless you have been diagnosed with diabetes.)
- 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.)

## 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 1-800-289-2250. 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).



## 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](http://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](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.**

## 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 íinízinigo t'áá diné k'éjügo, t'áá shoodí ba na'alnihí ya sidáhi bich'i naabííilkiid. Eí doo biigha daago ni ba'nija'go ho'aalagíí bich'i hodiilní. Hai'daą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béesh bee hane'i wólta' bi'ki si'niilígíí bi'kéhgo bich'i 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: \$7,350
- Patient pays: \$190

#### 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          | \$0          |
| Limits or exclusions | \$150        |
| <b>Total</b>         | <b>\$190</b> |

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

- Amount owed to providers: \$5,400
- Plan pays: \$4,570
- Patient pays: \$830

#### 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               | \$750        |
| Coinsurance          | \$0          |
| Limits or exclusions | \$80         |
| <b>Total</b>         | <b>\$830</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**, **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 1-800-289-2250 or visit us at [www.anthem.com/ca](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 [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-800-289-2250 to request a copy.