CalCPA Health Select HMO 10/0%

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

Coverage Period: 01/01/2018 – 12/31/2018

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.calcpahealth.com or by calling 1-877-480-7923.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	Yes. **$150** Individual/**$300** Family for brand name drugs.	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. **$1,750** Individual/**$3,500** Family for participating providers.	The **out-of-pocket limit** is the most you could pay during a coverage period (one calendar 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 does not cover.	Even though you pay these expenses, they do not count toward the **out-of-pocket limit**.
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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **participating providers**, see **www.anthem.com/ca** or call **1-888-209-7847**.	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 hospital or doctor's office may use out-of-network providers in their facility. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes.	This plan will pay some of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan does not cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **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 an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay/visit	Not covered	——————none——————
	Specialist visit	$10 copay/visit	Not covered	——————none——————
	Other practitioner office visit	$10 copay/visit for chiropractor and acupuncture	Not covered	Limited to 60 day period of care after an illness or injury without preauthorization. Failure to obtain preauthorization after the 60 days may result in reduced or non-coverage. Acupuncture must be medically necessary and referred by your primary care doctor. Acupressure is not covered.
	Preventive care/screening/immunization	No charge	Not covered	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	——————none——————

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Express-Scripts.com.	Generic drugs	$10/prescription	$10/prescription plus 50% coinsurance	————————none————————
	Formulary brand drugs	$25/prescription	$25/prescription plus 50% coinsurance	————————none————————
	Non-Formulary brand drugs	$45/prescription	$45/prescription plus 50% coinsurance	————————none————————
	Self-injectable drugs	30% coinsurance up to $250	30% coinsurance plus 50% of the remaining maximum allowed amount	Self-injectable drugs are not available through mail order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	————————none————————
	Physician/surgeon fees	No charge	Not covered	————————none————————
If you need immediate medical attention	Emergency room services	$100 copay/visit	$100 copay/visit	Copay waived if admitted. Failure to obtain authorization after 24 hours may result in reduced or non-coverage.
	Emergency medical transportation	No charge	No charge	————————none————————
	Urgent care	$10 copay/visit	Not covered	Failure to obtain preauthorization may result in reduced or non-coverage.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	————————none————————
	Physician/surgeon fee	No charge	Not covered	————————none————————

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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	Not covered	$10/office visit.
	Mental/Behavioral health inpatient services	No charge	Not covered	Failure to obtain preauthorization visit may result in reduced or non-coverage
	Substance use disorder outpatient services	No charge	Not covered	$10/office visit.
	Substance use disorder inpatient services	No charge	Not covered	Failure to obtain preauthorization visit may result in reduced or non-coverage
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	$150 copay for elective abortions including Mifepristone taken in the doctor's office.
	Delivery and all inpatient services	No charge	Not covered	Failure to obtain authorization after 48 hours may result in reduced or non-coverage
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Must be a home health care agency. Limited to 100 visits/calendar year.
	Rehabilitation services	$10 copay/visit	Not covered	You may have up to a 60 day period of care after an illness or injury, starting at the time of your first visit for rehabilitative care. This does not limit the number of visits/treatments you may have within the 60 day period.
	Habilitation services	$10 copay/visit	Not covered	Rehabilitation and habilitation visits count towards rehabilitation visit limit.
	Skilled nursing care	No charge	Not covered	Limited to 100 visits per calendar year.
	Durable medical equipment	No charge	Not covered	————————none————————
	Hospice service	No charge	Not covered	Written care plan must be sent to your medical group every 30 days.
If your child needs dental or eye care	Eye exam	No charge	Not covered	Limited to one exam per year.
	Glasses	No charge	Not covered	Limited to 1 pair of glasses/year.
	Dental check-up	No charge	Not covered	$60 annual deductible per child.

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
- Adult dental care
- Infertility treatment
- Long-term care
- Most coverage provided outside the U.S. See www.BCBS.com/bluecardworldwide
- Non-emergency care when traveling outside the U.S.
- Adult routine eye care
- Routine foot care
- Weight loss programs
- Private-duty nursing (except covered under home health benefits)

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 (limits apply)
- Chiropractic Care (limits apply)
- Hearing aids (limits apply)

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 1-877-480-7923. 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, of the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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 Life and Health Insurance Company
ATTN: Appeals
P.O. Box 54159, Los Angeles, CA 90054

Additionally, 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
www.healthhelp.ca.gov
helpline@dmhc.ca.gov

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 adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíiłkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

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** $7,370
- **Patient pays** $170

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	$0
Copays	$20
Coinsurance	$0
Limits or exclusions	$0
Total	**$170**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,820
- **Patient pays** $580

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	$0
Copays	$400
Coinsurance	$100
Limits or exclusions	$80
Total	**$580**

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.