Anthem Blue Cross and Blue Shield
Anthem Premier DirectAccess - gyaa

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

Coverage Period: 03/01/2014 – 02/28/2015
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 or by calling (855) 330-1214.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0** person / **$0** family for In-Network Provider. **$2,000** person / **$4,000** family for Non-Network Provider. Does not apply to Copayments, Emergency Room Services, Home Health Care, and Prescription Drugs. In-Network Provider and Non-Network Provider deductibles are separate and do not count towards each other.	You must pay all costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** 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 **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes; **$2,500** person / **$5,000** family for In-Network Provider. **$5,000** person / **$10,000** family for Non-Network Provider. In-Network Provider and Non-Network Provider Out of Pocket are separate and do not count towards each other.	The **out-of-pocket limit** 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 out–of–pocket limit?	Premiums, Balance-Billed charges, and Health Care This Plan Doesn't	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.

Questions: Call (855) 330-1214 or visit us at www.anthem.com
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 or call (855) 330-1214 to request a copy.

Important Questions	Answers	Why this Matters:
	Cover.	
Is there an overall annual limit on what the plan pays?	No; This policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 3 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; See **www.anthem.com** or call **(855) 330-1214** for a list of participating providers.	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 doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No; You do not need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
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 **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 **In-Network provider** 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 a Non-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	30% coinsurance	--------none--------
	Specialist visit	$20 copay	30% coinsurance	--------none--------
	Other practitioner office visit	Chiropractor $10 copay Acupuncturist Not covered	Chiropractor 30% coinsurance Acupuncturist Not covered	Chiropractor Coverage is limited to 30 visits per calendar year. In-Network Provider and Non-Network Provider combined. Acupuncturist --------none--------
	Preventive care/screening/immunization	No charge	30% coinsurance	--------none--------
If you have a test	Diagnostic test (x-ray, blood work)	Lab - Office 10% coinsurance X-Ray – Office 10% coinsurance	Lab - Office 30% coinsurance X-Ray – Office 30% coinsurance	Lab - Office --------none-------- X-Ray – Office --------none--------
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is	Tier 1 - Typically Generic	$10 copay per prescription (retail only) and $25 copay per prescription (mail order only)	30% coinsurance (retail only)	Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (mail order program).
	Tier 2 - Typically Preferred/Formulary Brand	$30 copay per prescription (retail	30% coinsurance (retail only)	Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
available at http://www.anthem.com/pharmacyinformation/		only) and $75 copay per prescription (mail order only)		supply (mail order program).
	Tier 3 – Typically Non-preferred/Non-formulary and Specialty Drugs	$60 copay or 25% coinsurance, whichever is greater up to $250 per prescription (retail only) and $150 copay or 25% coinsurance, whichever is greater up to $625 per prescription (mail order only).	30% coinsurance (retail only)	Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (mail order program).
	Tier 4 -Typically Specialty Drugs	Not covered	Not covered	--------none--------
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 copay and then 10% coinsurance	30% coinsurance	Costs may vary by site of service. You should refer to your formal contract of coverage for details.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	--------none--------
If you need immediate medical attention	Emergency room services	$150 copay and then 10% coinsurance	$150 copay and then 10% coinsurance	Copay waived if admitted.
	Emergency medical transportation	10% coinsurance	10% coinsurance	--------none--------
	Urgent care	$20 copay	30% coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 per day copay up to $750 per admission and then 10% coinsurance	30% coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Physician/surgeon fee	10% coinsurance	30% coinsurance	--------none--------
If you have mental health, behavioral	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit	Mental/Behavioral Health Office Visit	Mental/Behavioral Health Office Visit

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
health, or substance abuse needs		$10 copay Mental/Behavioral Health Facility Visit-Facility Charges $150 copay and then 10% coinsurance	30% coinsurance Mental/Behavioral Health Facility Visit-Facility Charges 30% coinsurance	--------none-------- Mental/Behavioral Health Facility Visit-Facility Charges --------none--------
	Mental/Behavioral health inpatient services	$250 per day copay up to $750 per admission and then 10% coinsurance	30% coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Substance use disorder outpatient services	Substance Abuse Office Visit $10 copay Substance Abuse Facility Visit - Facility Charges $150 copay and then 10% coinsurance	Substance Abuse Office Visit 30% coinsurance Substance Abuse Facility Visit - Facility Charges 30% coinsurance	Substance Abuse Office Visit --------none-------- Substance Abuse Facility Visit -Facility Charges --------none--------
	Substance use disorder inpatient services	$250 per day copay up to $750 per admission and then 10% coinsurance	30% coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
If you are pregnant	Prenatal and postnatal care	$150 copay	30% coinsurance	Your doctor's charges for delivery are part of prenatal and postnatal care.
	Delivery and all inpatient services	$250 per day copay up to $750 per admission and then 10% coinsurance	30% coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced coverage. Applies to inpatient facility. Other cost shares may apply depending on services provided.
If you need help recovering or have other special health	Home health care	$10 copay	30% coinsurance	--------none--------
	Rehabilitation services	$10 copay	30% coinsurance	Coverage for speech therapy is limited to 30 visits per calendar year and physical

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
needs				therapy and occupational therapy combined is limited to 30 visits per calendar year. In-Network Provider and Non-Network Provider combined. Costs may vary by site of service. You should refer to your formal contract of coverage for details.
	Habilitation services	$10 copay	30% coinsurance	Habilitation and Rehabilitation visits count towards your Rehabilitation limit.
	Skilled nursing care	$250 per day copay up to $750 per admission and then 10% coinsurance	30% coinsurance	Coverage is limited to 100 days per admission. In-Network Provider and Non-Network Provider combined. Failure to obtain preauthorization may result in non-coverage or reduced coverage. Costs may vary by site of service. You should refer to your formal contract of coverage for details.
	Durable medical equipment	10% coinsurance	30% coinsurance	--------none--------
	Hospice service	No charge	30% coinsurance	--------none--------
If your child needs dental or eye care	Eye exam	No charge	Total cost less $30 Reimbursement.	Coverage is limited to 1 exam every benefit period/12 months. $30 maximum benefit per visit if use a Non-Network Provider.
	Glasses	No charge	Total cost less $45 Reimbursement for frames and $25 Reimbursement for Single lenses, $40 Reimbursement for bifocal lenses and $55 Reimbursement for trifocal lenses.	Coverage is limited to 1 set of glasses every benefit period/12 months.
	Dental check-up	No charge	30% coinsurance	--------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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Infertility treatment
- Long-term 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.)

- Chiropractic care
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide.
- Private-duty nursing Coverage is limited to 16 hours per calendar year.
- Routine eye care (adult) Coverage is limited to 1 exam per benefit period

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 (855) 330-1214. 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, or 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:

ATTN: Grievances and Appeals
P.O. Box 27401
Richmond, VA 23279

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

Virginia Bureau of Insurance
1300 East Main Street
P. O. Box 1157
Richmond, VA 23218
(800) 552-7945

Additionally, a consumer assistance program can help you file your appeal. Contact
Virginia State Corporation Commission
Life and Health Division, Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
(877) 310-6560
http://www.scc.virginia.gov/boi
bureauofinsurance@scc.virginia.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:

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 adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'alníhí ya sidáhí bich'į naabídíłkiid. 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.

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..

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** $5,500
- **Patient pays** $2,100

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	$1,700
Coinsurance	$400
Limits or exclusions	$0
Total	$2,100

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact: www.anthem.com or (855) 330-1214.

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,800
- **Patient pays** $700

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	$200
Total	$700

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: www.anthem.com or (855) 330-1214.

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.