City of Los Angeles Access+ HMO® (Full) Zero Admit 15

Coverage Period: 01/01/2015-12/31/2015

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 www.blueshieldca.com/lacity or by calling **1-855-201-2086; TTY 1-800-241-1823**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**.	See the chart starting on page 2 for your costs for services this plan covers.
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 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For plan providers: **$500** per individual / **$1,000** per two persons / **$1,500** per family.	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, cost sharing for certain services listed in formal contract of coverage, and health care this plan doesn't cover.	Even though you pay these expenses, they don't 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. See www.blueshieldca.com/lacity **or call 1-855-201-2086; TTY 1-800-241-1823** for a list of plan 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 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes. Members need written approval to see a specialist except for OB/GYN or pediatrician serving as Primary Care Physician. Members may self refer using the Access+ Self Referral feature or for	The plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.

Important Questions	Answers	Why this Matters:
	OB/GYN services. Please see the formal contract of coverage for details.	
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 10. 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 plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copayment / visit	Not Covered	No charge for children under age 5. For other services received during the office visit, additional member cost-share may apply.
	Specialist visit	$15 copayment / visit	Not Covered	No charge for children under age 5. For other services received during the office visit, additional member cost-share may apply. $30 copayment per visit for Access+ Specialist Self Referral.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
	Other practitioner office visit	Chiropractic: $15 copayment / visit Acupuncture: $15 copayment / visit	Not Covered	Coverage for chiropractic and acupuncture services is limited to 50 combined visits per calendar year. Services are provided by American Specialty Health (ASH) Network. Coverage for chiropractic appliances is limited to $50 per calendar year.
	Preventive care/screening /immunization	No Charge	Not Covered	Preventive health services are only covered when provided by plan providers. Coverage for services consistent with ACA requirements and California laws. Please refer to your plan contract for details.
If you have a test	Diagnostic test (x-ray, blood work)	Lab & Path at Free Standing Location: No Charge X-Ray & Imaging at Free Standing Radiology Center: No Charge Other Diagnostic Examination at Free Standing Location: No Charge X-Ray, Lab & Other Examination at Outpatient Hospital: No Charge	Not Covered	Benefits in this section are for diagnostic, non-preventive health services. Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	Radiological & Nuclear Imaging at Free Standing Radiology Center: No Charge Radiological & Nuclear Imaging at Outpatient Hospital: No Charge	Not Covered	Benefits in this section are for diagnostic, non-preventive health services. Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.blueshieldca.com/lacity	Generic drugs	Retail: $10 copayment / prescription Mail Order: $20 copayment / prescription	Not Covered	Retail: Covers up to a 30-day supply; Mail Order: Covers up to a 90-day supply. Select formulary and non-formulary drugs require pre-authorization.
	Brand Formulary Drugs	Retail: $20 copayment / prescription Mail Order: $40 copayment / prescription	Not Covered	
	Brand Non-Formulary Drugs	Retail: $40 copayment / prescription Mail Order: $80 copayment / prescription	Not Covered	

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
	Specialty drugs	Applicable Retail Drug Copayment Applies	Not Covered	Covers up to a 30-day supply. Coverage limited to drugs dispensed by select pharmacies in the Specialty Pharmacy Network unless medically necessary for a covered emergency. Pre-authorization is required.
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 copayment / visit	$100 copayment / visit	Copayment waived if admitted; standard inpatient hospital facility benefits apply. This is for the hospital/facility charge only. The ER physician charge is separate. Coverage outside of California under BlueCard.
	Emergency medical transportation	No Charge	No Charge	----------None----------
	Urgent care	Within Plan service area: $15 copayment / visit Outside Plan service area: $15 copayment / visit	Within Plan service area: Not Covered Outside Plan service area: $15 copayment / visit	No charge for children under age 5.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits.
	Physician/surgeon fee	No Charge	Not Covered	----------None----------

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Mental Health Routine Outpatient Services: $15 copayment / visit Mental Health Non-Routine Outpatient Services: $15 copayment / visit	Not Covered	No charge for children under age 5. Mental Health Routine Outpatient Services: Services include professional/physician office visits. Mental Health Non-Routine Outpatient Services: Services include behavioral health treatment, electroconvulsive therapy, intensive outpatient programs, partial hospitalization programs, and transcranial magnetic simulation. Higher copayment and facility charges per episode of care may apply for partial hospitalization programs. Pre-authorization from Mental Health Service Administrator (MHSA) is required for non-routine outpatient mental health services. Failure to obtain pre-authorization may result in non-payment of benefits.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
	Mental/Behavioral health inpatient services	Mental Health Inpatient Hospital Services: No Charge Mental Health Residential Services: No Charge Mental Health Inpatient Physician Services: No Charge	Not Covered	Pre-authorization from Mental Health Service Administrator (MHSA) is required. Failure to obtain pre-authorization may result in non-payment of benefits.
	Substance use disorder outpatient services	Substance Abuse Routine Outpatient Services: $15 copayment / visit Substance Abuse Non-Routine Outpatient Services: $15 copayment / visit	Not Covered	No charge for children under age 5. Substance Abuse Routine Outpatient Services: Services include professional/physician office visits. Substance Abuse Non-Routine Outpatient Services: Services include partial hospitalization program, intensive outpatient program, and office-based opioid treatment. Higher copayment and facility charges per episode of care may apply for partial hospitalization programs. Pre-authorization from Mental Health Service Administrator (MHSA) is required for non-routine outpatient substance abuse services. Failure to obtain pre-authorization may result in non-payment of benefits.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
	Substance use disorder inpatient services	Substance Abuse Inpatient Hospital Services: No Charge Substance Abuse Residential Services: No Charge Substance Abuse Inpatient Physician Services: No Charge	Not Covered	Pre-authorization from Mental Health Service Administrator (MHSA) is required. Failure to obtain pre-authorization may result in non-payment of benefits.
If you are pregnant	Prenatal and postnatal care	Prenatal: No Charge Postnatal: No Charge	Not Covered	Prenatal: $15 copayment for initial visit only.
	Delivery and all inpatient services	No Charge	Not Covered	----------None----------

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Coverage limited to 100 visits per member per calendar year. Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits.
	Rehabilitation services	Office visit: $15 copayment / visit Outpatient hospital: $15 copayment / visit	Not Covered	Coverage for physical, occupational and respiratory therapy services.
	Habilitation services	Office visit: $15 copayment / visit Outpatient hospital: $15 copayment / visit	Not Covered	
	Skilled nursing care	No Charge	Not Covered	Coverage limited to 100 days per member per calendar year combined with hospital/free-standing skilled nursing facility. Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits.
	Durable medical equipment	No Charge	Not Covered	Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
	Hospice service	No Charge	Not Covered	Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits.
If your child needs dental or eye care	Eye exam	Covered by Blue Shield Vision Plan	Covered by Blue Shield Vision Plan	Please refer to Vision plan documents for further details.
	Glasses	Covered by Blue Shield Vision Plan	Covered by Blue Shield Vision Plan	Please refer to Vision plan documents for further details.
	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/Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private -duty nursing (unless enrolled in a participating hospice program)
- Routine foot care (unless for treatment of 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 (coverage limited to 50 combined visits with chiropractic per calendar year.)	• Chiropractic care (coverage limited to 50 combined visits with acupuncture per calendar year.)	• Infertility treatment (coverage for diagnosis and treatment of cause of infertility only.)
• Bariatric surgery (Pre-authorization from primary care physician and medical plan is required. Failure to obtain pre-authorization may result in non-payment of benefits.)	• Hearing aids (coverage limited to one hearing aid per ear every 24 months.)	• Routine eye care (Adult/Child) (Covered by Blue Shield Vision Plan.)

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 **1-855-201-2086; TTY 1-800-241-1823**. 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** X **61565** 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: **1-855-201-2086; TTY 1-800-241-1823** or the Department of Labor's Employee Benefits Security Administration at **1-866-444-EBSA (3272)** or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your **appeal**. Contact California Department of Managed Health Care Help at **1-888-466-2219** or visit http://www.healthhelp.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:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-346-7198.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-346-7198.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-866-346-7198.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-346-7198.

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	$150
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	$500
Coinsurance	$0
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.
- Plan and patient payments are based on a single person enrolled on the plan or policy.

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 **1-855-201-2086; TTY 1-800-241-1823** or visit us at www.blueshieldca.com/lacity.
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.dol.gov/ebsa/healthreform or call **1-866-444-3272** to request a copy.