Prescription Drug Benefits for Anthem HMO Select Plan

Coverage Period: 01/01/2020 – 12/31/2020

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: Individual + Family | Plan Type: RX Only**

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.Caremark.com or by calling **1-888-752-7229.**

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?	**$0**	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?	**$0**	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out–of–pocket limit?	This plan has no **out-of-pocket limit.**	Not applicable because there's no **out-of-pocket limit** on your expenses.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limit 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 in-network retail pharmacies and mail order locations, see www.caremark.com or call 1-888-752-7229. For medical plan providers like doctors and hospitals, refer to the separate Summary of Benefits and Coverage (SBC) document that describes the Anthem HMO Select Medical plan.	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 kind of **providers.**
Do I need a referral to see a specialist?	No. For information on whether a referral is needed to see a specialist, refer to the separate Summary of Benefits and Coverage (SBC) document that describes the Anthem HMO Select Medical plan.	You can see the **specialist** choose without the permission of this plan.
Are there services this plan doesn't cover?	Yes. For information on services not covered by the medical plan, refer to the separate Summary of Benefits and Coverage (SBC) document that describes the Anthem HMO Select Medical plan.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services.**

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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**.
- 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 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	Not applicable.	Not applicable.	For information on whether this is a covered service and your cost if you use an In-Network Provider or an Out-of-Network Provider, refer to the separate Summary of Benefits Coverage (SBC) document that describes the Anthem HMO Select Medical plan.
	Specialist visit	Not applicable.	Not applicable.	
	Other practitioner office visit	Not applicable.	Not applicable.	
	Preventive care/screening/immunization	Not applicable.	Not applicable.	
If you have a test	Diagnostic test (x-ray, blood work)	Not applicable.	Not applicable.	
	Imaging (CT/PET scans, MRIs)	Not applicable.	Not applicable.	

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.caremark.com	Generic drugs	$5 copay /Rx at retail; $10 copay / Rx at mail order.	You pay 100% and later can send the receipts to Caremark for partial reimbursement no more than it would have paid had you used an In-Network Retail pharmacy.	Covers up to a 34-day supply (retail); 90-day supply maintenance drugs (CVS/pharmacy or mail order). If you purchase a brand drug when a generic drug is available you pay a higher co-insurance. If the cost of the drug is less than the copayment, you pay just the drug cost. Contact Caremark at 1-888-752-7229 for information on drugs that need preapproval, quantity limits or have step therapy requirements.
	Preferred brand drugs	$25 copay /Rx at retail; $50 copay /Rx at mail order.		
	Non-preferred brand drugs	$45 copay /Rx at retail; $90 copay /Rx at mail order.		
	Specialty drugs	Same copay /Rx as retail copays listed above depending on whether drug is generic, preferred brand, or non-preferred brand.	Not covered. Specialty drugs must be ordered through Caremark at 1-888-752-7229.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not applicable.	Not applicable.	For information on whether this is a covered service and your cost if you use an In-Network Provider or an Out-of-Network Provider, refer to the separate Summary of Benefits and Coverage (SBC) document that describes the Anthem HMO Select Medical plan.
	Physician/surgeon fees	Not applicable.	Not applicable.	
If you need immediate medical attention	Emergency room services	Not applicable.	Not applicable.	
	Emergency medical transportation	Not applicable.	Not applicable.	
	Urgent care	Not applicable.	Not applicable.	
If you have a hospital stay	Facility fee (e.g., hospital room)	Not applicable.	Not applicable.	
	Physician/surgeon fee	Not applicable.	Not applicable.	

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	Not applicable.	Not applicable.	For information on whether this is a covered service and your cost if you use an In-Network Provider or an Out-of-Network Provider, refer to the separate Summary of Benefits (SBC) document that describes the Anthem HMO Select Medical plan.
	Mental/Behavioral health inpatient services	Not applicable.	Not applicable.	
	Substance use disorder outpatient services	Not applicable.	Not applicable.	
	Substance use disorder inpatient services	Not applicable.	Not applicable.	
If you are pregnant	Prenatal and postnatal care	Not applicable.	Not applicable.	For information on whether this is a covered service and your cost if you use an In-Network Provider or Out-of-Network Provider, refer to the separate Summary of Benefits and Coverage (SBC) document that describes the Anthem HMO Select Medical plan.
	Delivery and all inpatient services	Not applicable.	Not applicable.	
If you need help recovering or have other special health needs	Home health care	Not applicable.	Not applicable.	
	Rehabilitation services	Not applicable.	Not applicable.	
	Habilitation services	Not applicable.	Not applicable.	
	Skilled nursing care	Not applicable.	Not applicable.	
	Durable medical equipment	Not applicable.	Not applicable.	
	Hospice service	Not applicable.	Not applicable.	
If your child needs dental or eye care	Eye exam	Not applicable.	Not applicable.	
	Glasses	Not applicable.	Not applicable.	
	Dental check-up	Not applicable.	Not applicable.	

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.)

- For information on whether the following services are a covered service and any limitations on coverage, refer to the separate Summary of Benefits and Coverage (SBC) document that describes the Anthem HMO Select Medical plan. Contact Anthem HMO Select for more information on Acupuncture, Bariatric Surgery, Chiropractic care, Cosmetic surgery, Dental care (Adult), Hearing aids, Infertility treatment, Long-term care, Non-emergency care when traveling outside the U.S., Private duty nursing, Routine eye care (Adult), Routine foot care and 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.)

- For information on whether the following services are a covered service and any limitations on coverage, refer to the separate Summary of Benefits and Coverage (SBC) document that describes the Anthem HMO Select Medical plan. Contact Anthem HMO Select for more information on Acupuncture, Bariatric Surgery, Chiropractic care, Cosmetic surgery, Dental care (Adult), Hearing aids, Infertility treatment, Long-term care, Non-emergency care when traveling outside the U.S., Private duty nursing, Routine eye care (Adult), Routine foot care and Weight loss programs.

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 1-213-241-4262. 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 1-877267-2323 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: **Caremark at 1-888-752-7229.**

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 (meaning the LAUSD outpatient HMO Select prescription drug benefit plus the HMO Select medical plan benefit) 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 (meaning the LAUSD outpatient HMO Select prescription drug benefit plus the HMO Select medical plan benefit) does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-752-7229.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-752-7229.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-888-752-7229.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-752-7229.

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:** $7,840
- **Plan pays** $380 in Rx drug expenses
- **Patient pays** $120 in RX drug expenses

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$500
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,840**

Patient pays:

Deductibles	$0
Copays	$20
Coinsurance	$0
Limits or exclusions	$100
Total	**$120**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,420 in Rx drug expeneses
- **Patient pays** $480 in RX drug expenses

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	$
Copays	$400
Coinsurance	$
Limits or exclusions	$80
Total	**$480**

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.