

■ **Ready to choose**  
*your benefits?*

**We can point you in the right direction.**

Non-Core - HMO  
Manpower Temporary Services  
Effective January 1, 2017



# You're ready to enroll. Let's take a look at your options.

In this guide, you'll find:

- How most health plans work
- Specialty offerings
- Frequently Asked Questions (FAQ)
- Plan details
- Your privacy and rights





# How your health plan works

Visit [anthem.com/ca/basics](https://www.anthem.com/ca/basics) to learn more.

## HMO

This plan covers services from doctors in your plan. You'll need to choose a main doctor, also called a primary care doctor, from the **Health Maintenance Organization** (HMO) plan. If you need a specialist, you'll most likely have to go through your primary care doctor to get a referral.

Some HMO plans may have different rules. So be sure to check your plan details.



The doctors, hospitals and other health care providers in your plan have agreed to charge lower rates for our members.



When you enroll, you'll probably need to opt-in for the coverage options in this section.

## More benefits for you

### Dental

Dental benefits not only protect your teeth, but can support overall health, too. Some conditions like heart disease, for example, have warning signs in the mouth and gums. That's why a quality dental plan is an important part of your benefits package.



#### You've got access

Your Anthem ID card gives you access to quality care from quality doctors.



You can register at [anthem.com/ca](https://www.anthem.com/ca) or on the Anthem BC Anywhere mobile app – your simple and convenient solution to managing your health.

## Frequently asked questions (FAQ)

### Can I keep my current doctor?

Yes, you can. But keep in mind that you get the most out of your benefits if you choose a doctor in your plan. Some plans cover only services from doctors in your plan, which means you pay for the full cost if you see a doctor outside of the plan. Other plans cover services from doctors outside the plan – but your plan pays more of the cost when you see a doctor in your plan. Be sure to check the details of your plan.

To find out if your doctor is in the plan, or to find a new doctor in the plan, go to our *Find a Doctor* tool on [anthem.com/ca](https://www.anthem.com/ca). You can search by specialty and check a doctor's training, certifications and member reviews. Be ready to enter your plan name to view the doctors that serve your plan. You can also use *Find a Doctor* on your smartphone.

### How do I enroll?

You enroll by filling out a paper form.

### How do I use my health plan when I need care?

After you enroll, your member ID card will come in the mail. Be sure to bring it with you to the doctor. You can also show a copy of your ID card from the Anthem mobile app.

### Can I manage my plan and health care on [anthem.com/ca](https://www.anthem.com/ca)?

Yes. As soon as you become a member, you'll be able to register at [anthem.com/ca](https://www.anthem.com/ca) or on the Anthem mobile app. It's designed to help you manage your health care and your benefits simply and conveniently. Many of our members find these self-service tools helpful:

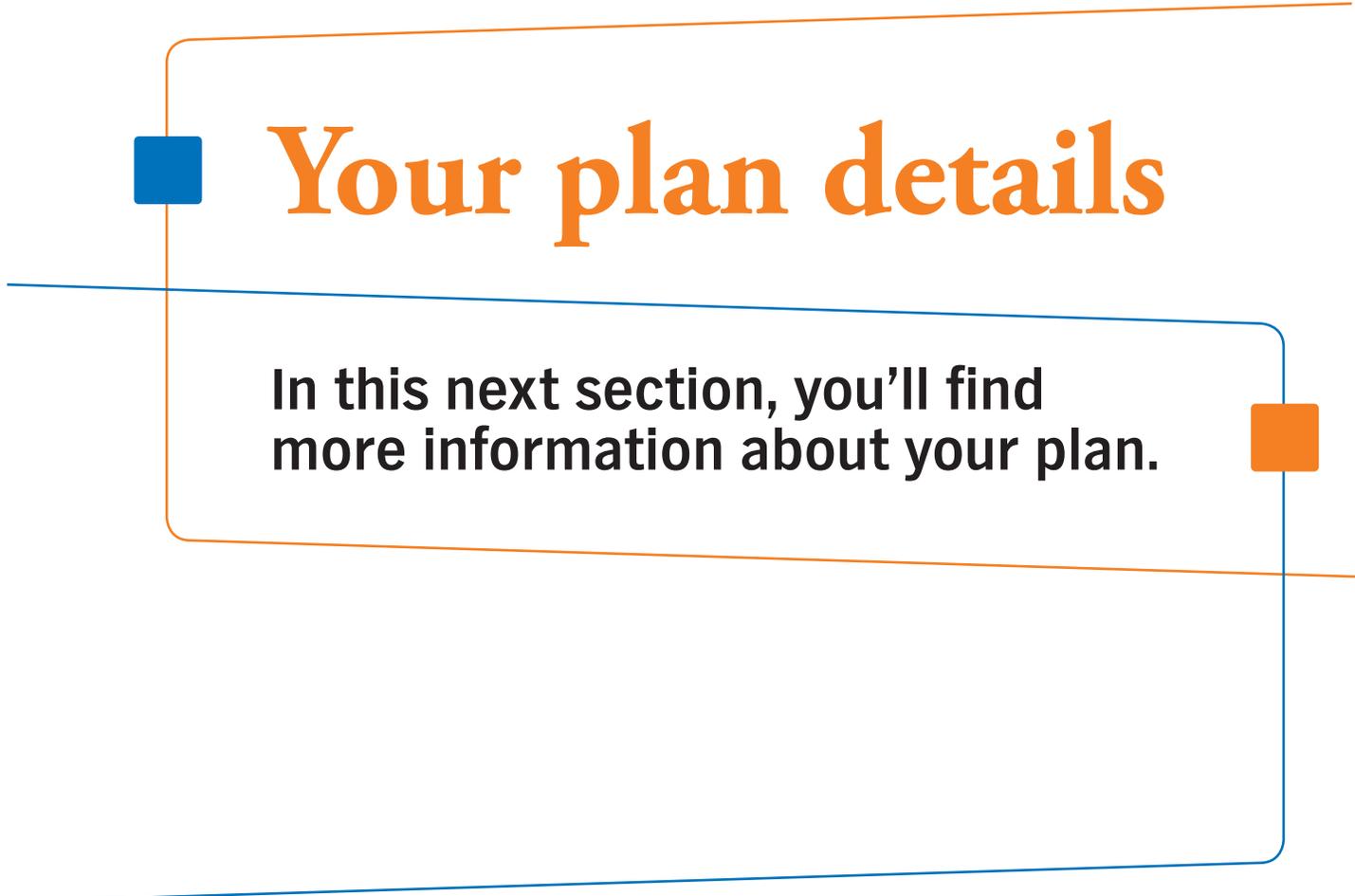
- Check on your claims.
- Find a doctor.
- Track your health care spending.
- Compare quality and costs at hospitals and other facilities.

Visit [anthem.com/ca/guidedtour](https://www.anthem.com/ca/guidedtour) to watch a video explaining how our website can help you.

### How can Anthem help me save money?

You'll save money every time you go to a doctor in your plan – they've agreed to charge lower rates for Anthem members. But we'll also help save you money before you go to the doctor.

At [anthem.com/ca](https://www.anthem.com/ca), you can compare how much a medical procedure will cost at different locations. Plus, all members get discounts on health-related products. You can even print your own coupons for healthier groceries.



# Your plan details

**In this next section, you'll find more information about your plan.** 

# Your summary of benefits



Anthem Blue Cross

Your Plan: Anthem Elements Choice EQ HMO 1500

Your Network: Priority Select HMO

*This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.*

*Anthem Blue Cross HMO benefits are covered only when services are provided or coordinated by the primary care physician and authorized by the participating medical group or independent practice association (IPA); except OB/GYN services received within the member's medical group/ IPA, and services for mental and nervous disorders and substance abuse. Benefits are subject to all terms, conditions, limitations, and exclusions of the EOC.*

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b> <i>See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.</i>	\$1,500 per member	\$0
<b>Out-of-Pocket Limit</b> <i>When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.</i>	\$6,400 single / \$12,800 family	\$0
<b>Preventive care/screening/immunization</b> <i>In-network preventive care is not subject to deductible, if your plan has a deductible.</i>	No charge	Not covered
<b>Doctor Home and Office Services</b>		
<b>Primary care visit to treat an injury or illness</b>	\$25 copay per visit	Not covered
<b>Specialist care visit</b>	\$50 copay per visit	Not covered
<b>Prenatal and Post-natal Care</b> <i>Deductible does not apply to In-Network providers.</i>	\$25 copay per visit	Not covered
<b>Other practitioner visits:</b>		
Retail health clinic	Not covered	Not covered
On-line Visit	Not covered	Not covered

# Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Chiropractor services <i>Coverage for In-Network Provider is limited to 60 day limit per benefit period for Physical, Occupational and Speech Therapy combined. Chiropractor visits count towards your physical and occupational therapy limit. Deductible does not apply to In-Network Providers.</i></p> <p>Acupuncture <i>Deductible does not apply to In-Network providers.</i></p>	<p>\$25 copay per visit</p> <p>\$25 copay per visit</p>	<p>Not covered</p> <p>Not covered</p>
<p><b>Other services in an office:</b></p> <p>Allergy testing <i>Deductible does not apply to In-Network providers.</i></p> <p>Chemo/radiation therapy <i>Deductible does not apply to In-Network providers.</i></p> <p>Hemodialysis <i>Deductible does not apply to In-Network providers.</i></p> <p>Prescription drugs <i>For the drugs itself dispensed in the office thru infusion/injection</i></p>	<p>\$25 copay per visit</p> <p>\$50 copay per visit</p> <p>\$50 copay per visit</p> <p>30% coinsurance up to \$150 per visit</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><b>Diagnostic Services</b></p> <p><b>Lab:</b></p> <p>Office</p> <p>Freestanding Lab</p> <p>Outpatient Hospital <i>Deductible applies.</i></p>	<p>No charge</p> <p>No charge</p> <p>30% coinsurance</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><b>X-ray:</b></p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital <i>Deductible applies.</i></p>	<p>No charge</p> <p>No charge</p> <p>30% coinsurance</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><b>Advanced diagnostic imaging (for example, MRI/PET/CAT scans):</b></p> <p>Office <i>Costs may vary by site of service.</i></p>	<p>\$250 copay per test</p>	<p>Not covered</p>

# Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Freestanding Radiology Center <i>Costs may vary by site of service.</i></p> <p>Outpatient Hospital <i>Deductible applies.</i></p>	<p>\$250 copay per test</p> <p>30% coinsurance</p>	<p>Not covered</p> <p>Not covered</p>
<p><b>Emergency and Urgent Care</b></p> <p><b>Emergency room facility services</b> <i>Deductible applies. This is for the hospital/facility charge only. The ER physician charge may be separate. Copay waived if admitted.</i></p> <p><b>Emergency room doctor and other services</b></p>	<p>\$250 copay and then 30% coinsurance</p> <p>No charge</p>	<p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p><b>Ambulance (air and ground)</b></p>	<p>\$100 copay per trip for ground and air</p>	<p>Covered as In-Network</p>
<p><b>Urgent Care (office setting)</b> <i>Copay waived if admitted. Costs may vary by site of service.</i></p>	<p>\$25 copay per visit</p>	<p>Covered as In-Network</p>
<p><b>Outpatient Mental/Behavioral Health and Substance Abuse</b></p> <p><b>Doctor office visit</b></p> <p><b>Facility visit:</b> Facility fees</p>	<p>\$25 copay for non-preventive visit medical deductible does not apply; then 0% coinsurance.</p> <p>No charge medical deductible does not apply.</p>	<p>Not covered</p> <p>Not covered</p>
<p><b>Outpatient Surgery</b></p> <p><b>Facility fees:</b></p> <p>Hospital <i>Deductible applies.</i></p> <p>Freestanding Surgical Center <i>Deductible applies.</i></p> <p><b>Doctor and other services</b></p>	<p>30% coinsurance</p> <p>30% coinsurance</p> <p>No charge</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>

# Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)</b></p> <p><b>Facility fees (for example, room &amp; board)</b> <i>Deductible applies.</i></p> <p><b>Doctor and other services</b></p>	<p>30% coinsurance</p> <p>No charge</p>	<p>Not covered</p> <p>Not covered</p>
<p><b>Recovery &amp; Rehabilitation</b></p> <p><b>Home health care</b> <i>Coverage for In-Network Provider is limited to 100 visit limit per benefit period. Deductible does not apply to In-Network Providers.</i></p>	<p>\$25 copay per visit</p>	<p>Not covered</p>
<p><b>Rehabilitation services (for example, physical/speech/occupational therapy):</b></p> <p>Office <i>Coverage for In-Network Provider is limited to 60 day limit per benefit period for Physical, Occupational and Speech Therapy combined. Costs may vary by site of service. Chiropractor visits count towards your physical and occupational therapy limit. Deductible does not apply to In-Network providers.</i></p> <p>Outpatient hospital <i>Coverage for In-Network Provider is limited to 60 day limit per benefit period for Physical, Occupational and Speech Therapy combined. Costs may vary by site of service.</i></p> <p>Habilitation services <i>Habilitation visits count towards your rehabilitation limit. Deductible applies.</i></p>	<p>\$25 copay per visit</p> <p>30% coinsurance</p> <p>30% coinsurance</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><b>Cardiac rehabilitation</b></p> <p>Office</p> <p>Outpatient hospital <i>Deductible applies.</i></p>	<p>\$25 copay per visit</p> <p>30% coinsurance</p>	<p>Not covered</p> <p>Not covered</p>
<p><b>Skilled nursing care (in a facility)</b> <i>Coverage for In-Network Provider is limited to 100 day limit per benefit period. Deductible applies.</i></p>	<p>30% coinsurance</p>	<p>Not covered</p>

# Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Hospice	No charge	Not covered
Durable Medical Equipment	50% coinsurance	Not covered
Prosthetic Devices	No charge	Not covered

# Your summary of benefits

## Notes:

- This Summary of Benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this Summary of Benefits. This Summary of Benefits, as updated, is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care (as applicable).
- In addition to the benefits described in this summary, coverage may include additional benefits, depending upon the member's home state. The benefits provided in this summary are subject to federal and California laws. There are some states that require more generous benefits be provided to their residents, even if the master policy was not issued in their state. If the member's state has such requirements, we will adjust the benefits to meet the requirements.
- Your plan requires a selection of a Primary Care Physician. Your plan requires a referral from your Primary Care Physician for select covered services.
- In Network and Non Network pharmacy deductibles are combined. Satisfying one helps satisfy the other. Pharmacy deductibles are included in the annual out-of-pocket maximums.
- The medical deductible applies to certain services such as: services in an inpatient/outpatient facility, emergency room. A separate pharmacy deductible applies to pharmacy benefits for applicable plans.
- Preventive Care Services includes physical exam, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunization, health education, intervention services, HIV testing) and additional preventive care for women provided for in the guidance supported by Health Resources and Service Administration.
- For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement is based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.
- Additional visits maybe authorized if medically necessary. Pre-service review must be obtained prior to receiving the additional services.
- Skilled Nursing Facility day limit does not apply to mental health and substance abuse.
- Respite Care limited to 5 consecutive days per admission.
- Freestanding Lab and Radiology Center is defined as services received in a non-hospital based facility.
- Infertility services are not included in the out of pocket amount.
- Coordination of Benefits: The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverage do not exceed 100% of the covered expense
- When using non-network pharmacy; members are responsible for in-network pharmacy copay plus 50% of the remaining prescription drug maximum allowed amount & costs in excess of the prescription drug maximum allowed amount. Members will pay upfront and submit a claim form.

# Your summary of benefits

- Supply limits for certain drugs may be different, go to Anthem website or call customer service.
- Certain drugs require pre-authorization approval to obtain coverage.
- For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to [https://le.anthem.com/pdf?x=CA\\_LG\\_HMO](https://le.anthem.com/pdf?x=CA_LG_HMO)
- For additional information on this plan, please visit [sbc.anthem.com](http://sbc.anthem.com) to obtain a Summary of Benefit Coverage.

# Your summary of benefits

Your Plan: Generic Premium \$15/\$35/30% \$500 Deductible

*This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Certificate of Insurance or Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.*

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Pharmacy Deductible</b>	\$500 per member / \$1,500 family	\$500 per member / \$1,500 family
<b>Pharmacy Out of Pocket</b>	\$0	\$0
<b>Prescription Drug Coverage</b> <i>This plan uses a Generic Premium List. Drugs not on the list are not covered.</i>		
<b>Preventive Pharmacy</b> Preventive Immunization <i>Prescription Drug deductible does not apply.</i>  Female oral contraceptive <i>Generic and Single Source brand Prescription Drug deductible does not apply.</i>	\$0 copay (retail only)  \$0 copay (retail only)	50% coinsurance (retail only)  50% coinsurance (retail only)
<b>Tier1 - Typically Generic</b> <i>Member pays the retail pharmacy copay plus 50% for out of network. Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program) Prescription Drug deductible does not apply.</i>	\$15 copay per prescription (retail only) and \$37.50 copay per prescription (home delivery only)	50% coinsurance (retail only)
<b>Tier2 - Typically Preferred / Brand</b> <i>Member pays the retail pharmacy copay plus 50% for out of network. Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program) No coverage for non-formulary drugs</i>	\$35 copay per prescription (retail only) and \$105 copay per prescription (home delivery only)	50% coinsurance (retail only)
<b>Tier3 - Typically Non-Preferred / Specialty Drugs</b> <i>Classified specialty drugs must be obtained through our Specialty Pharmacy</i>	30% coinsurance up to \$250 per	50% coinsurance (retail only)

Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Questions: (855) 333-5730 or visit us at [www.anthem.com/ca](http://www.anthem.com/ca)

CA/L/F/RX ONLY /LR2071/NA/01-16

14

# Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<i>Program and are subject to the terms of the program. Member pays the retail pharmacy copay plus 50% for out of network. Covers up to a 30 day supply (retail pharmacy and home delivery program) No coverage for non-formulary drugs</i>	prescription (retail and home delivery)	
<b>Tier4 - Typically Specialty Drugs</b>	Not covered	Not covered
<b>Infertility Drugs</b>	Not covered	Not covered

**Notes:**

- When using non-network pharmacy; members are responsible for in-network pharmacy copay plus 50% of the remaining prescription drug maximum allowed amount & costs in excess of the prescription drug maximum allowed amount. Members will pay upfront and submit a claim form.
- Supply limits for certain drugs may be different, go to Anthem website or call customer service.
- Certain drugs require pre-authorization approval to obtain coverage.
- In Network and Non Network pharmacy deductibles are combined. Satisfying one helps satisfy the other. Pharmacy deductibles are included in the annual out-of-pocket maximums.

**Your Summary of Benefits  
CPM LTD, Inc. dba ManPower  
Anthem Dental Prime**



Health · Dental · Vision · Life · Disability

**WELCOME TO YOUR DENTAL PLAN!**

This benefit summary outlines how your dental plan works and provides you with a quick reference of your dental plan benefits. For complete coverage details, please refer to your certificate of coverage.

**Dental coverage you can count on**

Your Anthem dental plan lets you visit any licensed dentist or specialist you want - with costs that are normally lower when you choose one within our large network.

**Savings beyond your dental plan benefits - you get more for your money.**

You pay our negotiated rate for covered services from in-network dentists even if you exceed your annual benefit maximum.

YOUR DENTAL PLAN AT A GLANCE		In-Network	Out-of-Network	
<b>Annual Benefit Maximum</b> ▪ Per insured person	Calendar Year	\$1,000	\$1,000	
<b>Annual Maximum Carryover</b>		No	No	
<b>Orthodontic Lifetime Benefit Maximum</b> ▪ Per eligible insured person		N/A	N/A	
<b>Annual Deductible</b> ▪ Per insured person ▪ Family maximum	Calendar Year	\$25 No Limit	\$50 No Limit	
<b>Deductible Waived for Diagnostic/Preventive Services</b>		Yes	No	
<b>Out-of-Network Reimbursement Options:</b>		Prime (MAC)		
Dental Services		In-Network Anthem Pays:	Out-of-Network Anthem Pays:	Waiting Period
<b>Diagnostic and Preventive Services</b> ▪ Periodic oral exam ▪ Teeth cleaning (prophylaxis) ▪ Bitewing X-rays: 1X per calendar year ▪ Intraoral X-rays		80% Coinsurance	50% Coinsurance	No Waiting Period
<b>Basic Services</b> ▪ Amalgam (silver-colored) Filling ▪ Front composite (tooth-colored) Filling ▪ Back composite Filling, Alternated to Amalgam Benefit ▪ Simple Extractions		60% Coinsurance	40% Coinsurance	No Waiting Period
<b>Endodontics</b> ▪ Root Canal		60% Coinsurance	40% Coinsurance	No Waiting Period
<b>Periodontics</b> ▪ Scaling and root planing		60% Coinsurance	40% Coinsurance	No Waiting Period
<b>Oral Surgery</b> ▪ Surgical Extractions		60% Coinsurance	40% Coinsurance	No Waiting Period
<b>Major Services</b> ▪ Crowns		40% Coinsurance	40% Coinsurance	12 Month
<b>Prosthodontics</b> ▪ Dentures ▪ Bridges ▪ Dental implants Not Covered		40% Coinsurance	40% Coinsurance	12 Month
<b>Prosthetic Repairs/Adjustments</b>		40% Coinsurance	40% Coinsurance	12 Month
<b>Orthodontic Services</b> ·None		Not Covered	Not Covered	N/A

This is not a contract; it is a partial listing of benefits and services. All covered services are subject to the conditions, limitations, exclusions, terms and provisions of your certificate of coverage. In the event of a discrepancy between the information in this summary and the certificate of coverage, the certificate will prevail.

ABC\_PCLG\_FI-Custom

**Emergency dental treatment for the international traveler**

As an Anthem dental member, you and your eligible, covered dependents automatically have access to the International Emergency Dental Program.\*\* With this program, you may receive emergency dental care from our listing of credentialed dentists while traveling or working nearly anywhere in the world.

\*\* The International Emergency Dental Program is managed by DeCare Dental, which is an independent company offering dental-management services to Anthem Blue Cross Life and Health Insurance Company.

**Promoting healthy mouths for members who are pregnant or living with diabetes**

If you are pregnant or living with diabetes, you can sign up to receive one additional dental cleaning or periodontal maintenance procedure per year.

**Finding a dentist is easy.**

To select a dentist by name or location, do one of the following:

- Go to [anthem.com/ca/mydental](http://anthem.com/ca/mydental)
- Call Customer Service at the toll-free number listed on the back of your ID card.

**TO CONTACT US:**

Call	Write
Refer to the toll-free number indicated on the back of your plan ID card to speak with a U.S.-based customer service representative during normal business hours. Calling after hours? We may still be able to assist you with our interactive voice-response system.	Refer to the back of your plan ID card for the address.

**Limitations & Exclusions**

Limitations – Below is a partial listing of dental plan limitations when these services are covered under your plan. Please see your certificate of coverage for a full list.

**Diagnostic and Preventive Services**

**Oral evaluations** (exam) Limited to two per Calendar Year

**Teeth cleaning** (prophylaxis) Limited to two per Calendar Year

**Intraoral X-rays, single film** Limited to four films per 12-month period

**Complete series X-rays** (panoramic or full-mouth) Coverage Every 5 Years

**Topical fluoride application** Limited to once every 12 months for members through age 18

**Sealants** Limited to first and second molars once every 24 months per tooth for members through age 15; sealants may be covered under Diagnostic and Preventive or Basic Services.

**Basic and/or Major Services\*\***

**Fillings** Limited to once per surface per tooth in any 24 months

**Space Maintainers** Limited to extracted primary posterior teeth once per lifetime per tooth for members through age 16; Space Maintainers may be covered under Diagnostic and Preventive or Basic Services.

**Crowns** Limited to once per tooth in a seven-year period

**Fixed or removable prosthodontics – dentures, partials, bridges**

Covered once in any seven-year period; benefits are provided for the replacement of an existing bridge, denture or partial for members age 16 or older if the appliance is seven years old or older and cannot be made serviceable.

**Root canal therapy** Limited to once per lifetime per tooth; coverage is for permanent teeth only.

**Periodontal surgery** Limited to one complex service per single tooth or quadrant in any 36 months, and only if the pocket depth of the tooth is five millimeters or greater

**Periodontal scaling and root planing** Limited to once per quadrant in 36 months when the tooth pocket has a depth of four millimeters or greater

**Brushed Biopsy** Not Covered

\*\*\***Waiting periods** for endodontic, periodontic and oral surgery services may differ from other Basic Services or Major Services under the same dental plan.

There is a waiting period of up to 24 months for replacement of congenitally missing teeth or teeth extracted prior to coverage under this plan.

**Exclusions – Below is a partial listing of noncovered services under your dental plan. Please see your certificate of coverage for a full list.**

**Services provided before or after the term of this coverage**

**Services received before your effective date or after your coverage ends, unless otherwise specified in the dental plan certificate**

**Orthodontics (unless included as part of your dental plan benefits)** Orthodontic braces, appliances and all related services

**Cosmetic dentistry** Services provided by dentists solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (cavities) exist

**Drugs and medications** Intravenous conscious sedation, IV sedation and general anesthesia when performed with nonsurgical dental care

Analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines or drugs for nonsurgical or surgical dental care except that intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

**Extractions -** Surgical removal of third molars (wisdom teeth) that do not exhibit symptoms or impact the oral health of the member

The in-network dental providers mentioned in this communication are independently contracted providers who exercise independent professional judgment. They are not agents or employees of Anthem Blue Cross Life and Health Insurance Company.



### Choice of dentists

While your dental plan lets you choose any dentist, you may end up paying more for a service if you visit an out-of-network dentist.

### Here's why:

In-network dentists have agreed to payment rates for various services and cannot charge you more. On the other hand, out-of-network dentists don't have a contract with us and are able to bill you for the difference between the total amount we allow to be paid for a service – called the "maximum allowed amount" – and the amount they usually charge for a service. When they bill you for this difference, it's called "balance billing."

### How Anthem dental decides on maximum allowed amounts

For services from an out-of-network dentist, the maximum allowed amount is determined in one of the following ways:

- Out-of-network dental fee schedule/rate developed by Anthem, which may be updated based on such things as reimbursement amounts accepted by dentists contracted with our dental plans, or other industry cost and usage data
- Information provided by a third-party vendor that shows comparable costs for dental services
- In-network dentist fee schedule

### Here's an example of higher costs for out-of-network dental services

This is an example only. Your experience may be different, depending on your insurance plan, the services you receive and the dentist who provides the services.

Ted gets a crown from an out-of-network dentist, who charges \$1,200 for the service and bills Anthem for that amount.

Anthem's maximum allowed amount for this dental service is \$800. That means there will be a \$400 difference, which the dentist can "balance bill" Ted.

Since Ted will also need to pay \$400 coinsurance, the total he'll pay the out-of-network dentist is \$800.

Here's the math:

- Dentist's charge: \$1,200
- Anthem's maximum allowed amount: \$800
- Anthem pays 50%: \$400
- Ted pays 50% (coinsurance): \$400
- Balance Ted owes the provider:  $\$1,200 - \$800 = \$400$
- Ted's total cost:  $\$400$  coinsurance +  $\$400$  provider balance = \$800

In the example, if Ted had gone to an in-network dentist, his cost would be only \$400 for the coinsurance because he would not have been "balance billed" the \$400 difference.



# Let's talk about your privacy and rights

As a member, you have the right to expect the privacy of your personal health information to be protected, consistent with state and federal laws and our policies. And you also have certain rights and responsibilities when receiving your health care.

To learn more about how we protect your privacy, your rights and responsibilities when receiving health care and your rights under the Women's Health and Cancer Rights Act, go to [www.anthem.com/ca/memberrights](http://www.anthem.com/ca/memberrights). To request a printed copy, please contact your Benefits Administrator or Human Resources representative.

## How we help manage your care

To decide if we'll cover a treatment, procedure or hospital stay, we use a process called Utilization Management (UM). UM is a program that lets us make sure you're getting the right care at the right time. Licensed health care professionals review information your doctor has sent us to see if the requested care is medically needed. These reviews can be done before, during or after a member's treatment. UM also helps us decide if the services will be covered by your health plan.

We also use case managers. They're licensed health care professionals who work with you and your doctor to help you learn about and manage your health conditions. They also help you better understand your health benefits.

To learn more about how we help manage your care, visit [www.anthem.com/ca/memberrights](http://www.anthem.com/ca/memberrights). To request a printed copy, please contact your Benefits Administrator or Human Resources representative.

## Special Enrollment Rights

There are certain situations when you can enroll in a plan outside the open enrollment period. Open enrollment usually happens only once a year. That's the time you can enroll in a plan or make changes to it. If you choose not to enroll during open enrollment, there are special cases when you're allowed to enroll yourself and your dependents. Special enrollment is allowed:

- **If you had another health plan that was canceled.** If you, your dependents or your spouse are no longer eligible for

other coverage (or if the employer stops contributing to your health plan), you may be able to enroll with us. You must enroll within 31 days after the other coverage ends (or after the employer stops paying for it).

- For example: You and your family are enrolled through your spouse's coverage at work. Your spouse's employer stops paying for health coverage. In this case, you and your spouse, as well as other dependents, may be able to enroll in a plan.
- **If you have a new dependent.** This could mean a life event like marriage, birth, adoption or if you have custody of a minor and an adoption is pending. You must enroll within 31 days after the event. For example: If you got married, your new spouse and any new children may be able to enroll in a plan.
- **If your eligibility for Medicaid or SCHIP changes.** You have a special period of 60 days to enroll after:
  - You (or your eligible dependents) lose Medicaid or CHIP coverage because you're no longer eligible.
  - You (or eligible dependents) become eligible to get help from Medicaid or SCHIP for paying part of the cost.











You've got health goals.  
We've got your back.



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'y, shikáa adootwoł íínízínigo t'áá diné k'éjígó, t'áá shoodí ba na'alníhí ya sidáhí bich'í naabídíłkiid. Eí doo biigha daago ni ba'nija'go ho'aalagí bich'í hodiilní. Hai'daą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígí ní béesh bee hane'y wólta' bi'ki si'níilígí bi'kéhgo bich'í 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.

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.

Life products underwritten by Anthem Blue Cross Life and Health Insurance Company. Disability products underwritten by Anthem Life Insurance Company.

Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross, Anthem Life Insurance Company and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Express Scripts, Inc. is a separate company that provides pharmacy services and pharmacy benefit management services on behalf of health plan members.

The Healthy Lifestyles programs are administered by Healthways, Inc., an independent company.