Frequently Asked Questions

Health Care Reform

Question: What is a Health Insurance Marketplace?
Answer: It’s a set of websites that are all set up the same way and that the government regulates. People can buy health insurance from the marketplaces with government aid called subsidies. All Health Insurance Marketplaces must be fully certified and running by January 1, 2014, by federal law. Also known as an “Exchange.”

Q: Do I have to buy from a Health Insurance Marketplace?
A: You can choose to buy insurance from an insurer like us or from a state or federal Health Insurance Marketplace. If you are eligible to get a subsidy and want to use one, you must buy your plan from a Health Insurance Marketplace.

Q: What are my Health Care Reform plan choices in 2014?
A: Under the new health care law, all new plans and those that aren’t grandfathered (see definition below) fit in one of four levels: bronze, silver, gold, or platinum. These levels make it easier to compare costs and benefits so you can choose the right plan for your needs.

- Plan Relative Premium Cost (how high your cost will be compared to the other plans)
- Your Share of Health Care Costs
- Bronze Lowest 40%
- Silver Average 30%
- Gold Higher 20%
- Platinum Highest 10%

Q: What is a grandfathered plan?
A: A health insurance plan that was bought or changed before March 23, 2010. These plans do not have to follow the new health care law. That includes, but is not limited to, benefits for preventive care at no cost and no lifetime benefit limit. You cannot add new people to a grandfathered plan. If you leave a grandfathered plan for any reason, you cannot go back to it.

Q: What is the Federal Premium Assistance Tax Credit?
A: Starting in 2014, eligible people can use a Federal Premium Assistance Tax Credit to help them pay the cost of insurance bought through a Health Insurance Marketplace. To be eligible, a person’s household income must be between 100 percent and 400 percent of the federal poverty level, and the person must either:

- Not be offered minimum essential coverage (what a person needs to have to meet the individual responsibility requirement) by an employer, or
- Be offered minimum essential coverage by an employer, but (i) the cost of the employer’s coverage is more than 9.5 percent of the employee’s household income, or (ii) the employer pays less than 60 percent of the plan’s total allowed costs of benefits.

General Health Insurance

Q: Do I have to meet my deductible (the amount you must pay for health care services) before my benefits start?
A: It depends on the type of plan you choose. Preventive care benefits start as soon as you enroll. Some plans also cover a specific number of office visits before the deductible is met, so you only pay a copay.

Q: What is preventive care?
A: It’s the care that helps you stay healthy. You get it in every bronze, silver, gold and platinum plan - as well as many grandfathered plans - at no extra cost. It includes:

- Yearly checkups
- Flu shots
- Routine shots (vaccinations)
- Mammograms
- Screenings, like cholesterol tests
- Vision exams for kids
Q: What's a provider network?
A: It's a group of doctors, hospitals and other health care providers that agree to accept lower rates for covered services from a health plan. You save money by choosing providers in your plan's network.

Q: Are the monthly premium amounts per person or for the family?
A: The amount you will pay is for all members listed in the quoting tool. If you meet certain criteria, you may be able to get a government subsidy and/or tax credit to lower the premium. The amount of financial help you could get depends on your income, family size and health care costs where you live. You can use our Subsidy Calculator to find out if you qualify for a credit.

Plans

Q: I already have an Individual and Family plan (not one sponsored by an employer) with you. Do I need to do anything?
A: You will need to move to a qualified health plan starting January 1, 2014. Log in to the secure Member Portal to see a comparison of the coverage you have now with the qualified health plan we recommend for you.

Q: What if I want specific benefits, like dental and vision coverage, that aren't part of a medical plan?
A: As part of the new health care laws, dental and vision benefits for kids will be either part of your health care plan or available as a separate policy. We also offer dental and vision plans for adults.

Prescriptions

Q: What is prescription drug coverage and how do I use it?
A: Prescription drug coverage helps cover the cost of your medicines. To find out if your medicine is covered, it's important to take a look at our drug list. It's also important to make sure the pharmacy you use is in-network. That helps to lower the cost of your medicines. You can get this information during what we call our open enrollment period. Your health plan identification (ID) card is also your prescription drug card. Just take your prescription and ID card to any in-network pharmacy. The pharmacist will look at your prescription and your benefits and, tell you how much your copay will be.

Q: Do I need to buy a separate pharmacy plan?
A: No. Pharmacy coverage is part of health plans for certain individuals and groups as of January 1, 2014. But it's a good idea to keep some of the questions below in mind when going over your plans benefits:

- What types of drugs are covered by the plan?
- Does the plan cover the drugs that you take daily or often?
- Does the plan offer an easy way for you to get your drugs, like a home delivery program?

Q: Can I have prescription medicines mailed to my home?
A: Yes, through our Home Delivery Complete program. You can have prescriptions filled and sent right to your home – with free, standard shipping. And you'll get the same high quality service you've come to expect from your local pharmacy. You may experience cost savings by using this program.

Q: What is a drug list?
A: A drug list has the names of the drugs that are covered under your plan. Drugs are put in certain groups called tiers. Several things are used to decide which tier a drug belongs in. They can include:

- How well the drug works when compared to other drugs used for the same type of treatment
- The cost of the drug as compared to other drugs used for the same type of treatment
- Is there a lower cost option that you can get over the counter (an OTC drug)

Q: How much will I pay for my prescriptions?
A: In most cases, your copay is a fixed dollar amount. For some drugs, you may have to pay a coinsurance amount, which is a percentage of the drug cost. The cost of each drug depends on which tier it is in and where you get it from (a retail pharmacy or through our Home Delivery Complete program). Tier 1 drugs have the lowest copay. Tier 4 drugs have the highest copay. And some pharmacy plans only have 3 tiers.

Q: How can I save money?
A: Consider over-the-counter (OTC) drugs. At times, they can be a very good choice because they can save you time and money over a prescription drug. Also, when talking to your doctor about prescriptions, ask your doctor if there is a generic option if he or she wrote
out a prescription for a brand-name drug. In general, you will pay less for generic drugs and more for brand-name drugs. Using our home delivery program may also help you save money.

Q: What is the difference between brand-name drugs and generics?
A: The Food and Drug Administration requires that brand-name drugs and generic drugs have the same:

- Active ingredients
- Strength
- High quality standards
- Dose

Even though the generic has a different name and might look different from the brand-name drug, it’s still just as safe and works just as well. The biggest difference is the price. If you’re taking a brand-name drug and would like to switch to a generic, speak with your doctor and see if it’s an option for you.

Q: Why do brand-name drugs cost more than most generic drugs?
A: Companies that make brand-name drugs pay for research and advertising. But most companies that make generics don’t. They pass the savings on to you.

Q: Can I have my prescription switched to a drug with a lower copay?
A: You may have this option. You should speak with your doctor to discuss possible options.

More Help

Q: Where do I go if I am a member who has questions about plan changes or adding benefits?
A: As a member with an individual plan, you can call our Membership department (877-208-8237) for plan recommendations or changes to the plan you already have. Or, you can call Customer Service at the number on the back of your ID card with any questions about your plan, billing or claims.

Q: If I have more questions about the products, benefits or rates on this site, whom should I contact?
A: You should speak to your agent. If you do not have an agent, please call the number at the top of the page or start a live chat and ask to speak with an agent.

Q: If I am having technical problems with this site, whom should I contact?
A: For technical support, call 866-755-2680.

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