Your summary of benefits

Anthem BlueCross

Anthem Blue Cross of California

Your Plan: Anthem Platinum PPO 20/10%/4000 Your

Network: Prudent Buyer PPO

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 Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$0	$2,000 person / $4,000 family
Out-of-Pocket Limit *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.*	$4,000 person / $8,000 family	$8,000 person / $16,000 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	50% coinsurance after deductible is met
Doctor Home and Office Services		
Primary care visit to treat an injury or illness	$20 copay per visit	50% coinsurance after deductible is met
Specialist care visit	$40 copay per visit	50% coinsurance after deductible is met
Prenatal and Post-natal Care *In-Network preventative prenatal and postnatal services are covered at 100%*	$20 copay per visit	50% coinsurance after deductible is met
Other practitioner visits: Retail health clinic	$20 copay per visit	50% coinsurance after deductible is

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		met
On-line Visit	$20 copay per visit	50% coinsurance after deductible is met
Chiropractor services *Coverage for In-Network Provider is limited to 20 visits per benefit period.*	50% coinsurance	Not Covered
Acupuncture	$20 copay per visit	50% coinsurance after deductible is met
Other services in an office:		
Allergy testing	10% coinsurance	50% coinsurance after deductible is met
Chemo/radiation therapy	10% coinsurance	50% coinsurance after deductible is met
Hemodialysis	10% coinsurance	50% coinsurance after deductible is met
Prescription drugs *For the drugs itself dispensed in the office thru infusion/injection*	10% coinsurance	50% coinsurance after deductible is met
Diagnostic Services		
Lab:		
Office	10% coinsurance	50% coinsurance after deductible is met
Freestanding Lab	10% coinsurance	50% coinsurance after deductible is met
Outpatient Hospital *Coverage for Non-Network Providers is limited to $380 maximum benefit per admission.*	10% coinsurance	50% coinsurance after deductible is met
X-ray:		
Office	10% coinsurance	50% coinsurance

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
		after deductible is met
Freestanding Radiology Center *Coverage for Non-Network Providers is limited to $380 maximum benefit per admission.*	10% coinsurance	50% coinsurance after deductible is met
Outpatient Hospital *Coverage for Non-Network Providers is limited to $380 maximum benefit per admission.*	10% coinsurance	50% coinsurance after deductible is met
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office *Coverage for Non-Network Providers is limited to $800 maximum benefit per procedure.*	10% coinsurance	50% coinsurance after deductible is met
Freestanding Radiology Center *Coverage for Non-Network Providers is limited to $380 maximum benefit per admission.*	10% coinsurance and then $100 copay	50% coinsurance after deductible is met
Outpatient Hospital *Coverage for Non-Network Providers is limited to $380 maximum benefit per admission.*	10% coinsurance and then $100 copay	50% coinsurance after deductible is met
Emergency and Urgent Care		
Emergency room facility services *Copay waived if admitted.*	$150 copay and then 10% coinsurance	Same as In Network
Emergency room doctor and other services	10% coinsurance	Same as In Network
Ambulance (air and ground)	10% coinsurance	Same as In Network
Urgent Care (office setting)	$40 copay per visit	50% coinsurance after deductible is met
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit	$20 copay per visit	50% coinsurance after deductible is met
Facility visit:		

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Facility fees	10% coinsurance	50% coinsurance after deductible is met
Outpatient Surgery		
Facility fees:		
Hospital *Coverage for Non-Network Providers is limited to $380 maximum benefit per admission.*	10% coinsurance	50% coinsurance after deductible is met
Freestanding Surgical Center *Coverage for Non-Network Providers is limited to $380 maximum benefit per admission.*	10% coinsurance	50% coinsurance after deductible is met
Doctor and other services	10% coinsurance	50% coinsurance after deductible is met
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)		
Facility fees (for example, room & board) *Coverage for Non-Network Providers is limited to $650 maximum benefit per day. Coverage for Inpatient rehabilitation and skilled nursing services combined In-Network Provider and Non-Network Provider combined is limited to 100 days per benefit period.*	10% coinsurance	50% coinsurance after deductible is met
Doctor and other services	10% coinsurance	50% coinsurance after deductible is met
Recovery & Rehabilitation		
Home health care *Coverage for In-Network Provider and Non-Network Provider combined is limited to 100 visits per benefit period. Coverage for Non-Network Providers is limited to $75 maximum benefit per visit.*	10% coinsurance	50% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office	10% coinsurance	50% coinsurance after deductible is

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
		met
Outpatient hospital *Coverage for Non-Network Providers is limited to $380 maximum benefit per admission.*	10% coinsurance	50% coinsurance after deductible is met
Habilitation services	10% coinsurance	50% coinsurance after deductible is met
Cardiac rehabilitation		
Office	10% coinsurance	50% coinsurance after deductible is met
Outpatient hospital *Coverage for Non-Network Providers is limited to $380 maximum benefit per admission.*	10% coinsurance	50% coinsurance after deductible is met
Skilled nursing care (in a facility) *Coverage for Non-Network Providers is limited to $150 maximum benefit per day. Coverage for Inpatient rehabilitation and skilled nursing services combined In-Network Provider and Non-Network Provider combined is limited to 100 days per benefit period.*	10% coinsurance	50% coinsurance after deductible is met
Hospice	10% coinsurance	50% coinsurance after deductible is met
Durable Medical Equipment	50% coinsurance	50% coinsurance after deductible is met
Prosthetic Devices	10% coinsurance	50% coinsurance after deductible is met

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Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	$0	$0
Pharmacy Out of Pocket	Combined with medical out of pocket	Not covered
Prescription Drug Coverage *Anthem Select Drug List*		
Tier 1a - Typically Lower Cost Generic *You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Covers up to a 90 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs.*	$5 copay per prescription (retail only) and $13 copay per prescription (home delivery only)	Not covered
Tier 1b - Typically Generic *Covers up to a 90 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs.*	$15 copay per prescription (retail only) and $38 copay per prescription (home delivery only)	Not covered
Tier 2 - Typically Preferred Brand & Non-Preferred Generics *Covers up to a 90 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs.*	$35 copay per prescription (retail only) and $105 copay per prescription (home delivery only)	Not covered
Tier 3 - Typically Non-Preferred Brand *Covers up to a 90 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs.*	$70 copay per prescription (retail only) and $210 copay per prescription (home delivery only)	Not covered
Tier 4 - Typically Specialty (brand and generic) *Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program). No coverage for non-formulary drugs.*	30% coinsurance up to $250 (retail and home delivery)	Not covered

Your summary of benefits

This is a brief outline of your vision coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. *Only children's vision services count towards your out of pocket limit.*		
Frames *Coverage for In-Network Provider and Non-Network Provider combined is limited to 1 unit per benefit period. Limited reimbursement up to maximum allowable for out of network services*	No charge	No charge
Elective contact lenses *Coverage for In-Network Provider and Non-Network Provider combined is limited to 1 unit per benefit period. Limited reimbursement up to maximum allowable for out of network services*	No charge	No charge

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Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Frames	Not covered	Not covered
Lenses	Not covered	Not covered
Elective contact lenses	Not covered	Not covered
Non-Elective Contact Lenses	Not covered	Not covered

Your summary of benefits

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your dental coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. *Only children's dental services count towards your out of pocket limit.*		
Children's Dental Essential Health Benefits **Diagnostic and preventive** *Coverage for In-Network Provider and Non-Network Provider combined is limited to 1 visit per6months.*	No charge	No charge
Basic services	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Major services	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Medical Necessary Orthodontia services	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Cosmetic Orthodontia services	Not covered	Not covered
Deductible	Combined with medical deductible	Combined with medical deductible
Adult Dental		
Diagnostic and preventive	Not covered	Not covered
Basic services	Not covered	Not covered
Major services	Not covered	Not covered
Deductible	Not Applicable	Not Applicable
Annual maximum	Not Applicable	Not Applicable

Notes:

- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.
- Coverage for Non-emergency ambulance service for Non-Network Providers is limited to $50,000 maximum benefit per occurrence.
- For additional information on this plan, please visit sbc.anthem.com to obtain a "Summary of Benefit Coverage".
- For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to ca.sgplans.anthem.com/ca/le
- All medical services subject to a coinsurance are also subject to the annual medical deductible.
- If your plan includes a hospital stay copay and you are readmitted within 72 hours of a prior admission for the same diagnosis, your hospital stay copay for your readmission is waived.
- Your copays, coinsurance and deductible count toward your out of pocket amount.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- If your plan includes out of network benefits and you use a non-participating provider, you are responsible for any difference between the covered expense and the actual non-participating providers charge.
- For plans with an office visit copay, the copay applies to the actual office visit and additional cost shares may apply for any other service performed in the office (i.e., X-ray, lab, surgery), after any applicable deductible.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.

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