# Your summary of benefits

Anthem BlueCross

Anthem Blue Cross of California

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

Your Network: Select 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**<br>*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**<br>*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**<br>*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**<br>*In-Network preventative prenatal and postnatal services are covered at 100%* | $20 copay per visit | 50% coinsurance after deductible is met |
| **Other practitioner visits:**<br>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<br>*Coverage for In-Network Provider and Non-Network Provider combined is limited to 20 visits per benefit period. Coverage for Non-Network Providers is limited to $25 maximum benefit per visit.* | 50% coinsurance | Not Covered |
| Acupuncture | $20 copay per visit | 50% coinsurance after deductible is met |
| **Other services in an office:** | | |
| Allergy testing | 10% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Chemo/radiation therapy | 10% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Hemodialysis | 10% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Prescription drugs<br>*For the drugs itself dispensed in the office thru infusion/injection* | 10% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Diagnostic Services** | | |
| **Lab:** | | |
| Office | 10% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Freestanding Lab | Not Applicable | Not Applicable |
| Outpatient Hospital<br>*Coverage for Non-Network Providers is limited to $380 maximum benefit per admission.* | 10% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **X-ray:** | | |

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|---|---|---|
| Office | 10% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Freestanding Radiology Center | Not Applicable | Not Applicable |
| Outpatient Hospital<br>*Coverage for Non-Network Providers is limited to $380 maximum benefit per admission.* | 10% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Advanced diagnostic imaging (for example, MRI/PET/CAT scans):** | | |
| Office<br>*Coverage for Non-Network Providers is limited to $800 maximum benefit per procedure.* | 10% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Freestanding Radiology Center | Not Applicable | Not Applicable |
| Outpatient Hospital<br>*Coverage for Non-Network Providers is limited to $380 maximum benefit per admission.* | 10% coinsurance and then $100 copay after deductible is met | 50% coinsurance after deductible is met |
| **Emergency and Urgent Care** | | |
| **Emergency room facility services**<br>*Copay waived if admitted.* | $150 copay and then 10% coinsurance after deductible is met | Same as In Network |
| **Emergency room doctor and other services** | 10% coinsurance after deductible is met | Same as In Network |
| **Ambulance (air and ground)** | 10% coinsurance after deductible is met | 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** | | |

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|---|---|---|
| **Doctor office visit** | $20 copay per visit | 50% coinsurance after deductible is met |
| **Facility visit:** | | |
| Facility fees | 10% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Outpatient Surgery** | | |
| **Facility fees:** | | |
| Hospital<br>*Coverage for Non-Network Providers is limited to $380 maximum benefit per admission.* | 10% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Freestanding Surgical Center | Not Applicable | Not Applicable |
| **Doctor and other services** | 10% coinsurance after deductible is met | 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)**<br>*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 after deductible is met | 50% coinsurance after deductible is met |
| **Doctor and other services** | 10% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Recovery & Rehabilitation** | | |
| **Home health care**<br>*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 after deductible is met | 50% coinsurance after deductible is met |
| **Rehabilitation services (for example,** | | |

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|---|---|---|
| **physical/speech/occupational therapy):** | | |
| Office | 10% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Outpatient hospital<br>*Coverage for Non-Network Providers is limited to $380 maximum benefit per admission.* | 10% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Habilitation services | 10% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Cardiac rehabilitation** | | |
| Office | 10% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Outpatient hospital<br>*Coverage for Non-Network Providers is limited to $380 maximum benefit per admission.* | 10% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Skilled nursing care (in a facility)**<br>*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 after deductible is met | 50% coinsurance after deductible is met |
| **Hospice** | 10% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Durable Medical Equipment** | 50% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Prosthetic Devices** | 10% coinsurance after deductible is met | 50% coinsurance after deductible is met |

# Your summary of benefits

| 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**<br>*Anthem Select Drug List* | | |
| **Tier 1a - Typically Lower Cost Generic**<br>*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**<br>*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**<br>*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**<br>*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)**<br>*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

| Covered Vision Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|
| *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.*<br>*Only children's vision services count towards your out of pocket limit.* | | |
| **Children's Vision Essential Health Benefits** | | |
| **Child Vision Deductible** | Not Applicable | Not Applicable |
| **Vision exam**<br>*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 |
| **Frames**<br>*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 |
| **Lenses**<br>*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**<br>*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 |
| **Non-Elective Contact Lenses**<br>*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 |
| **Adult Vision** | | |
| **Adult Vision Deductible** | Not Applicable | Not Applicable |
| **Vision exam**<br>*Coverage for In-Network Provider and Non-Network Provider combined is limited to 1 exam per benefit period. Coverage for Non-Network Providers is limited to $30 maximum benefit per visit.* | $20 copay per visit | No charge |

# Your summary of benefits

| 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.*<br>*Only children's dental services count towards your out of pocket limit.* | | |
| **Children's Dental Essential Health Benefits**<br>**Diagnostic and preventive**<br>*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**<br>*Applies to all services except diagnostic & preventive* | 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.
- Your coinsurance and deductible count toward your out of pocket amount
- 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.