

# Your summary of benefits



Anthem Blue Cross of California

Your Contract Code: 3053

Your Plan: Anthem Platinum Select PPO 20/10%/3000

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
<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>	\$0	\$2,000 person / \$4,000 family
<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>	\$3,000 person / \$6,000 family	\$6,000 person / \$12,000 family
<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	50% coinsurance after deductible is met
<b>Doctor Home and Office Services</b>  <b>Primary care visit to treat an injury or illness</b>	\$20 copay per visit	50% coinsurance after deductible is met
<b>Specialist care visit</b>	\$40 copay per visit	50% coinsurance after deductible is met
<b>Routine Prenatal Care</b>	No charge	50% coinsurance after deductible is met

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Routine Postnatal Care</b>	\$20 copay per visit	50% coinsurance after deductible is met
<b>Other practitioner visits:</b> Retail health clinic	\$10 copay per visit	50% coinsurance after deductible is met
On-line Visit <i>Live Health Online is the preferred telehealth solutions</i> <a href="http://www.livehealthonline.com">www.livehealthonline.com</a>	\$10 copay per visit	50% coinsurance after deductible is met
Chiropractic <i>Coverage for In-Network Providers is limited to 20 visits per benefit period for spinal manipulation.</i>	50% coinsurance	Not covered
Acupuncture	\$20 copay per visit	Not covered
<b>Other services in an office:</b> 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 <i>For the drugs itself dispensed in the office thru infusion/injection</i>	10% coinsurance	50% coinsurance after deductible is met
<b>Diagnostic Services</b> <b>Lab:</b> Office	10% coinsurance	50% coinsurance after deductible is met

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

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>Doctor office visit</b></p> <p><b>Facility visit:</b></p> <p>    Facility fees</p> <p>    Doctor Services</p>	<p>No charge</p> <p>10% coinsurance</p> <p>10% coinsurance</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><b>Outpatient Surgery</b></p> <p><b>Facility fees:</b></p> <p>    Hospital  <i>Coverage for Non-Network Providers is limited to \$380 maximum benefit per admission.</i></p> <p><b>Doctor and other services:</b></p> <p>    Hospital</p>	<p>10% coinsurance</p> <p>10% coinsurance</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<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>Coverage for Inpatient rehabilitation and skilled nursing services combined In-Network Providers and Non-Network Providers combined is limited to 100 days per benefit period. Coverage for Non-Network Providers is limited to \$650 maximum benefit per day.</i></p> <p><b>Doctor and other services</b></p>	<p>10% coinsurance</p> <p>10% coinsurance</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><b>Recovery &amp; Rehabilitation</b></p>		

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>Home health care</b>  <i>Coverage for Home Health and Private Duty Nursing combined In-network Providers and Non-Network Providers combined is limited to 100 4-hour visits per calendar year. Coverage for Non-Network Providers is limited to \$75 maximum benefit per visit.</i></p>	10% coinsurance	50% coinsurance after deductible is met
<p><b>Rehabilitation services (for example, physical/speech/occupational therapy):</b></p> <p>Office</p> <p>Outpatient hospital  <i>Coverage for Non-Network Providers is limited to \$380 maximum benefit per admission.</i></p> <p><b>Habilitation services (for example, physical/speech/occupational therapy):</b></p> <p>Office</p> <p>Outpatient hospital  <i>Coverage for Non-Network Providers is limited to \$380 maximum benefit per admission.</i></p>	<p>10% coinsurance</p> <p>10% coinsurance</p> <p>10% coinsurance</p> <p>10% coinsurance</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><b>Cardiac rehabilitation</b></p> <p>Office</p> <p>Outpatient hospital  <i>Coverage for Non-Network Providers is limited to \$380 maximum benefit per admission.</i></p>	<p>10% coinsurance</p> <p>10% coinsurance</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><b>Skilled nursing care (in a facility)</b>  <i>Coverage for Inpatient rehabilitation and skilled nursing services combined In-Network Providers and Non-Network Providers combined is limited to 100 days per benefit period. Coverage for Non-Network Providers is limited to \$150 maximum benefit per day.</i></p>	10% coinsurance	50% coinsurance after deductible is met

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Hospice</b>	No charge	50% coinsurance after deductible is met
<b>Durable Medical Equipment</b>	50% coinsurance	50% coinsurance after deductible is met
<b>Prosthetic Devices</b>	10% coinsurance	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
<b>Pharmacy Deductible</b>	Not Applicable	Not Applicable
<b>Pharmacy Out of Pocket</b>	Combined with medical out of pocket	Not covered
<b>Prescription Drug Coverage</b> <i>Anthem Select Drug List</i> <i>This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.</i>		
<b>Tier 1a - Typically Lower Cost Generic</b> <i>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>	\$5 copay per prescription (retail only). \$13 copay per prescription (home delivery only).	Not covered
<b>Tier 1b - Typically Generic</b> <i>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>	\$15 copay per prescription (retail only). \$38 copay per prescription (home delivery only).	Not covered
<b>Tier 2 - Typically Preferred Brand &amp; Non-Preferred Generics</b> <i>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). \$105 copay per prescription (home delivery only).	Not covered
<b>Tier 3 - Typically Non-Preferred Brand</b> <i>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>	\$70 copay per prescription (retail only). \$210 copay per prescription (home delivery only).	Not covered

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Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Tier 4 - Typically Specialty (brand and generic)</b> <i>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.</i>	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
<p><i>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.</i></p>		
<p><b>Children's Vision Essential Health Benefits</b></p> <p><b>Child Vision Deductible</b></p> <p><b>Vision exam</b>  <i>Coverage for In-Network Providers and Non-Network Providers combined is limited to 1 exam per benefit period.</i></p>	<p>\$0 person            No charge</p>	<p>\$0 person            No charge</p>
<p><b>Frames</b>  <i>Coverage for In-Network Providers and Non-Network Providers combined is limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>No charge</p>
<p><b>Lenses</b>  <i>Coverage for In-Network Providers and Non-Network Providers combined is limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>No charge</p>
<p><b>Elective contact lenses</b>  <i>Coverage for In-Network Providers and Non-Network Providers combined is limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>No charge</p>
<p><b>Non-Elective Contact Lenses</b>  <i>Coverage for In-Network Providers and Non-Network Providers combined is limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>No charge</p>
<p><b>Adult Vision</b></p> <p><b>Adult Vision Deductible</b></p> <p><b>Vision exam</b>  <i>Coverage for In-Network Providers and Non-Network Providers combined is limited to 1 exam per benefit period.</i></p>	<p>\$0 person            \$20 copay per visit</p>	<p>\$0 person            Amount above \$30 reimbursement</p>
<p><b>Frames</b></p>	<p>Not covered</p>	<p>Not covered</p>
<p><b>Lenses</b></p>	<p>Not covered</p>	<p>Not covered</p>
<p><b>Elective contact lenses</b></p>	<p>Not covered</p>	<p>Not covered</p>

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Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
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
<p><i>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.</i></p> <p><i>Only children's dental services count towards your out of pocket limit.</i></p>		
<p><b>Children's Dental Essential Health Benefits</b>  <b>Diagnostic and preventive</b>  <i>Coverage for In-Network Providers and Non-Network Providers combined is limited to 1 visit per 6 months.</i></p>	No charge	No charge
<p><b>Basic services</b></p>	50% coinsurance	50% coinsurance
<p><b>Major services</b></p>	50% coinsurance	50% coinsurance
<p><b>Medically Necessary Orthodontia services</b></p>	50% coinsurance	50% coinsurance
<p><b>Cosmetic Orthodontia services</b></p>	Not covered	Not covered
<p><b>Deductible</b></p>	Combined with medical deductible	Combined with medical deductible
<p><b>Adult Dental</b></p>		
<p><b>Diagnostic and preventive</b></p>	Not covered	Not covered
<p><b>Basic services</b></p>	Not covered	Not covered
<p><b>Major services</b></p>	Not covered	Not covered
<p><b>Deductible</b></p>	Not covered	Not Applicable
<p><b>Annual maximum</b></p>	Not covered	Not covered

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Your plan also includes the following Healthy Support & Rewards features.

To see your rewards and additional information log into the Anthem website at [anthem.com/ca](http://anthem.com/ca) or call the customer service number on your member ID card.

## **ONLINE WELLNESS TOOLKIT**

The Online Wellness Toolkit helps participants set and achieve personalized health goals while leveraging health assessment results to recommend areas of focus that will lower a participant's most significant health risks.

## **COMMERCIAL OUTBOUND CALL PROGRAM**

Providing live outbound calls to members and providers to help members become aware of and address health related gaps in care. Assisting members to locate a provider, schedule appointments & learn how to be more effective in taking their meds.

## **BEHAVIORAL HEALTH CASE MANAGEMENT (COMB)**

The Behavioral Health Care Management Program (aka Comorbid Medical/Behavioral program or COMB) is an Enterprise-wide core offering to those accounts that have not carved out their behavioral health benefit. It is an all-inclusive, integrated case management program offering a fluid approach to dealing with the complex comorbid medical and behavioral health conditions or strictly psychiatric illnesses.

## **CONDITIONCARE: CORE**

Gain a better understanding of your health, receive help in following your doctor care plan, and learn how to better manage your health with the guidance of a dedicated nurse team and health professionals

## **TRANSPLANT**

Members that are identified for an organ or tissue transplant (excludes cornea and includes kidney for

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	<p>most groups, but not all; NA IHM does not manage cornea or kidney transplant) are contacted by the Transplant program for CM before, during and after transplant. The transplant CM manages UM during the transplant episode of care and CM to ensure that members are treated in the best facilities (BDCT/CME) and have the best quality and cost outcomes.</p>
<b>AUTISM SPECTRUM DISORDER (ASD) PROGRAM</b>	<p>ASD Program provides specialized UM and CM to our members with an ASD diagnosis</p>
<b>MYHEALTH ADVANTAGE GOLD</b>	<p>Provides timely alerts, called MyHealth Notes, which notify you of possible gaps in medical care, medication alerts or possible ways to save money</p>
<b>24/7 NURSELINE</b>	<p>Provides anytime, toll-free access to nurses for answers to general health questions and guidance with health concerns. Callers can also access confidential, recorded messages about hundreds of health topics</p>
<b>FUTURE MOMS WITH ID AND NO MAILERS</b>	<p>Provides moms-to-be with telephone access to nurses to discuss pregnancy-related concerns. This program provides the education and tools to help track the pregnancy week-by-week and prepare for the baby</p>
<b>CONDITIONCARE:ESRD</b>	<p>ConditionCare ESRD</p>

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## 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.
- Covered out-of-network Human Organ and Tissue Transplant services do not apply toward the out-of-pocket limit
- Your coinsurance, copays and deductible count toward your out of pocket amount.
- 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](http://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](http://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.
- 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.
- Certain services are subject to the utilization review program or precertification. Before scheduling services, the member must make sure utilization or precertification review is obtained. If utilization or precertification review is not obtained, benefits may be reduced or not paid according to the plan.

# Your summary of benefits

## Get help in your language

### Language Assistance Services



Curious to know what all this says? We would be too. Here's the English version:

**IMPORTANT:** Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

#### Spanish

**IMPORTANTE:** ¿Puede leer esta carta? De lo contrario, podemos hacer que alguien lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721. (TTY/TDD: 711)

#### Arabic

مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاستعانة بشخص ما لمساعدتك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم 1-888-254-2721 (TTY/TDD: 711).

#### Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող ենք նաև այս նամակը Ձեզ գրավոր տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-888-254-2721 հեռախոսահամարով: (TTY/TDD: 711)

#### Chinese

**重要事項:** 您能看懂這封信函嗎? 如果您看不懂, 我們能夠找人協助您。您有可能可以獲得以您的語言而寫的本信函。如需免費協助, 請立即撥打1-888-254-2721。(TTY/TDD: 711)

#### Farsi

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر نمی‌توانید، می‌توانیم شخصی را به شما معرفی کنیم تا در خواندن این نامه شما را کمک کند. همچنین می‌توانید این نامه را به صورت مکتوب به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، همین حالا با شماره 1-888-254-2721 تماس بگیرید. (TTY/TDD: 711)

#### Hindi

**महत्वपूर्ण:** क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम आपको इसे पढ़ने में मदद करने के लिए किसी को उपलब्ध करा सकते हैं। आप यह पत्र अपनी भाषा में लिखवाने में भी सक्षम हो सकते हैं। निःशुल्क मदद के लिए, कृपया 1-888-254-2721 पर तुरंत कॉल करें। (TTY/TDD: 711)

#### Hmong

**TSEEM CEEB:** Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwm tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

#### Japanese

