Anthem Blue Cross of California
Anthem Platinum 90 PPO (a Tiered PPO Plan)

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2016 – 12/31/2016
Coverage for: Individual + Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com/ca/sbc or by calling (855) 634-3381.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$5,000** person / **$10,000** family for Out-of-Network Providers. Does not apply to Prescription Drugs	See the chart starting on page for your costs for services this plan covers. You must pay all costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 3 for to see if the deductible applies, and how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes; **$4,000** person / **$8,000** family for In-Network Providers. **$10,000** person / **$20,000** family for Out-of-Network Providers	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, Balance-Billed charges, and Health Care This Plan Doesn't Cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes, Pathway X – PPO Tiered. For a list of In-Network providers, see www.anthem.com/ca or call	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or

Important Questions	Answers	Why this Matters:
	(855) 634-3381. Dental and Vision benefits may access a different network of providers.	participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No; You do not need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 10. See your policy or plan document for additional information about **excluded services.**

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **In-Network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost if You Use a Preferred Network Hospital Provider	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not Applicable	$20 copay per visit	60% coinsurance after deductible is met	--------none--------
	Specialist visit	Not Applicable	$40 copay per visit	60% coinsurance after deductible is met	--------none--------
	Other practitioner office visit	Not Applicable	$20 copay per visit	60% coinsurance after deductible is met	--------none--------
	Preventive care/screening/ immunization	Not Applicable	No charge	60% coinsurance after deductible is met	--------none--------
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office Not Applicable X-Ray – Office Not Applicable	Lab – Office $20 copay per visit X-Ray – Office $40 copay per visit	Lab – Office 60% coinsurance after deductible is met X-Ray – Office 60% coinsurance after deductible is met	Lab – Office --------none-------- X-Ray – Office --------none--------

Common Medical Event	Services You May Need	Your Cost if You Use a Preferred Network Hospital Provider	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	Not Applicable	10% coinsurance	60% coinsurance after deductible is met	--------none--------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.anthem.com/pharmacyinformation/ Anthem Select Drug List	Tier 1 - Typically Generic	$5 copay per prescription (retail only) and $10 copay per prescription (home delivery only)	$5 copay per prescription (retail only) and $10 copay per prescription (home delivery only)	60% coinsurance after deductible is met per prescription (retail only)	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..
	Tier 2 - Typically Preferred Brand	$15 copay per prescription (retail only) and $37.50 copay per prescription (home delivery only)	$15 copay per prescription (retail only) and $37.50 copay per prescription (home delivery only)	60% coinsurance after deductible is met per prescription (retail only	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.
	Tier 3 - Typically Non-preferred Specialty Drugs	$25 copay per prescription (retail only) and $62.50 copay per prescription (home delivery only)	$25 copay per prescription (retail only) and $62.50 copay per prescription (home delivery only)	60% coinsurance after deductible is met per prescription (retail only	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.
	Tier 4 - Typically Specialty Drugs	10% coinsurance up to $250 per	10% coinsurance up to $250 per	60% coinsurance after deductible is	Covers up to a 30 day supply (retail

Common Medical Event	Services You May Need	Your Cost if You Use a Preferred Network Hospital Provider	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
		prescription (retail only) 10% coinsurance up to $750 per prescription (home delivery only)	prescription (retail only) 10% coinsurance up to $750 per prescription (home delivery only)	met per prescription (retail only	pharmacy). Covers up to a 30 day supply (home delivery program). No coverage for non-formulary drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Applicable	10% coinsurance	60% coinsurance after deductible is met	--------none--------
	Physician/surgeon fees	Not Applicable	10% coinsurance	60% coinsurance after deductible is met	--------none--------
If you need immediate medical attention	Emergency room services	Not Applicable	Emergency Room Facility Fee $150 copay per visit Emergency Room Physician Fee 10% coinsurance	Emergency Room Facility Fee Covered as In-Network Emergency Room Physician Fee Covered as In-Network	Emergency Room Facility Fee Copay waived if admitted. Emergency Room Physician Fee Copay waived if admitted.
	Emergency medical transportation	Not Applicable	$150 copay per trip	Covered as In-Network	--------none--------
	Urgent care	Not Applicable	$40 copay per visit	Covered as In-Network	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	60% coinsurance after deductible is met	--------none--------
	Physician/surgeon fee	10% coinsurance	10% coinsurance	60% coinsurance after deductible is met	--------none--------

Common Medical Event	Services You May Need	Your Cost if You Use a Preferred Network Hospital Provider	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit Not Applicable Mental/Behavioral Health Other Outpatient Items and Services Not Applicable	Mental/Behavioral Health Office Visit $20 copay per visit Mental/Behavioral Health Other Outpatient Items and Services $20 copay	Mental/Behavioral Health Office Visit 60% coinsurance after deductible is met Mental/Behavioral Health Other Outpatient Items and Services 60% coinsurance after deductible is met	Mental/Behavioral Health Office Visit --------none-------- Mental/Behavioral Health Other Outpatient Items and Services --------none--------
	Mental/Behavioral health inpatient services	Inpatient facility fee 10% coinsurance Inpatient physician fees 10% coinsurance	Inpatient facility fee 40% coinsurance Inpatient physician fees 10% coinsurance	Inpatient facility fee 60% coinsurance after deductible is met Inpatient physician fees 60% coinsurance after deductible is met	Inpatient facility fee --------none-------- Inpatient physician fees --------none--------
	Substance use disorder outpatient services	Substance Use Disorder Office Visit Substance Abuse Not Applicable Substance Use Disorder Other Outpatient Items and Services	Substance Use Disorder Office Visit $20 copay per visit Substance Use Disorder Other Outpatient Items and Services $20 copay	Substance Use Disorder Office Visit 60% coinsurance after deductible is met Substance Use Disorder Other Outpatient Items and Services	Substance Use Disorder Office Visit --------none-------- Substance Use Disorder Other Outpatient Items and Services --------none--------

Common Medical Event	Services You May Need	Your Cost if You Use a Preferred Network Hospital Provider	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
		Not Applicable		60% coinsurance after deductible is met	
	Substance use disorder inpatient services	Inpatient facility fee 10% coinsurance Inpatient physician fees 10% coinsurance	Inpatient facility fee 40% coinsurance Inpatient physician fees 10% coinsurance	Inpatient facility fee 60% coinsurance after deductible is met Inpatient physician fees 60% coinsurance after deductible is met	Inpatient facility fee --------none-------- Inpatient physician fees --------none--------
If you are pregnant	Prenatal and postnatal care	Not Applicable	10% coinsurance	60% coinsurance after deductible is met	In-Network preventive prenatal and postnatal services are covered at 100%.
	Delivery and all inpatient services	10% coinsurance	40% coinsurance	60% coinsurance after deductible is met	Applies to inpatient facility. Other cost shares may apply depending on services provided.
If you need help recovering or have other special health needs	Home health care	Not Applicable	10% coinsurance	60% coinsurance after deductible is met	Coverage for Network and Non-Network Providers combined is

Common Medical Event	Services You May Need	Your Cost if You Use a Preferred Network Hospital Provider	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
					limited to 100 visits per benefit period.
	Rehabilitation services	Not Applicable	$20 copay per visit	60% coinsurance after deductible is met	--------none--------
	Habilitation services	Not Applicable	$20 copay per visit	60% coinsurance after deductible is met	--------none--------
	Skilled nursing care	10% coinsurance	10% coinsurance	60% coinsurance after deductible is met	Coverage for Network and Non-Network Providers combined is limited to 100 days per benefit period.
	Durable medical equipment	Not Applicable	10% coinsurance	60% coinsurance after deductible is met	--------none--------
	Hospice service	Not Applicable	No charge	60% coinsurance after deductible is met	--------none--------
If your child needs dental or eye care	Eye exam	Not Applicable	No charge	No charge	Coverage for In-Network Providers and Non-Network Provider combined is limited to 1 exam

Common Medical Event	Services You May Need	Your Cost if You Use a Preferred Network Hospital Provider	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
					per benefit period.
	Glasses	Not Applicable	No charge	No charge	Coverage for In-Network Providers and Non-Network Provider combined is limited to 1 exam per benefit period.
	Dental check-up	Not Applicable	No charge	No charge	Coverage for In-Network Providers and Non-Network Provider combined is limited to 1 exam per benefit period.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide.
- Private-duty nursing
- Non-Formulary drugs
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at (855) 634-3381. You may also contact your state insurance department at:

Department of Managed Health Care
California Help Center
980 9th Street
Suite 500
Sacramento, CA 95814-2725
(888) HMO-2219

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

ATTN: Grievances and Appeals
P.O. Box 4310
Woodland Hills, CA 91365-4310

Department of Managed Health Care
California Help Center
980 9th Street
Suite 500
Sacramento, CA 95814-2725
(888) HMO-2219

California Department of Managed Health Care Help Center
980 9th Street, Suite 500
Sacramento, CA 95814
(888) 466-2219
http://www.healthhelp.ca.gov
helpline@dmhc.ca.gov

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy <u>does</u> provide minimum essential coverage.**

Language Access Services:

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'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíłkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į 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 mãi 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.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About These Coverage Examples:

These examples show how this plan might cover
medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,060
- **Patient pays** $480

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$80
Coinsurance	$400
Limits or exclusions	$0
Total	$480

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $5,011
- **Patient pays** $389

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$60
Coinsurance	$29
Limits or exclusions	$300
Total	$389

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co payments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call (855) 634-3381 or visit us at www.anthem.com/ca

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call (855) 634-3381 to request a copy.