Anthem Blue Cross of California
Anthem Platinum Select PPO 20/10%/4000 Plus

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

Coverage Period: 12/01/2015 – 11/30/2016
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) 383-7248.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,000** person / **$4,000** family for Out-of-Network Providers. Does not apply to Prescription Drugs.	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 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. **$8,000** person / **$16,000** 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, Select PPO. For a list of In-Network providers, see www.anthem.com/ca or call **(855) 383-7248**. Dental and Vision benefits may access a different network of providers.	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 participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **providers**.

Important Questions	Answers	Why this Matters:
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 7. 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 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	$20 copay per visit	50% coinsurance	--------none--------
	Specialist visit	$40 copay per visit	50% coinsurance	--------none--------
	Other practitioner office visit	Chiropractor $20 copay per visit Acupuncture $20 copay per visit	Chiropractor 50% coinsurance Acupuncture 50% coinsurance	Chiropractor Coverage for In-Network Providers and Non-Network Providers combined is limited to 20 visits per benefit period. Coverage for Non-Network Providers is limited to $25 maximum benefit per visit. Acupuncture --------none--------
	Preventive care/screening/immunization	No charge	50% coinsurance	--------none--------
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office $20 copay per visit X-Ray – Office $40 copay per visit	Lab – Office 50% coinsurance X-Ray – Office 50% coinsurance	Lab – Office --------none-------- X-Ray – Office --------none--------
	Imaging (CT/PET scans, MRIs)	10% coinsurance	50% coinsurance	Coverage for Non-Network Providers is limited to $800 maximum benefit per procedure.
If you need drugs to treat your illness or condition More information	Tier 1 - Typically Generic	$5 copay per prescription (retail only) and $12.50 copay per	50% coinsurance (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.

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
about **prescription drug coverage** is available at http://www.anthem.com/pharmacyinformation/ Anthem Select Drug List		prescription (home delivery only)		
	Tier 2 - Typically Preferred/Formulary Brand	$15 copay per prescription (retail only) and $37.50 copay per prescription (home delivery only)	50% coinsurance (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/Non-formulary and Specialty Drugs	$25 copay per prescription (retail only) and $62.50 copay per prescription (home delivery only)	50% coinsurance (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 $500 (retail and home delivery)	50% coinsurance (retail only)	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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	50% coinsurance	Coverage for Non-Network Providers is limited to $380 maximum benefit per admission.
	Physician/surgeon fees	10% coinsurance	50% coinsurance	--------none--------
If you need immediate medical attention	Emergency room services	$150 copay per visit	Covered as In-Network	Copay waived if admitted.
	Emergency medical transportation	$150 copay per trip	Covered as In-Network	--------none--------
	Urgent care	$40 copay per visit	50% coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	50% coinsurance	Coverage for Non-Network Providers is limited to $650 maximum benefit per day.
	Physician/surgeon fee	10% coinsurance	50% coinsurance	--------none--------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit $20 copay per visit Mental/Behavioral Health Facility Visit-	Mental/Behavioral Health Office Visit 50% coinsurance Mental/Behavioral Health Facility Visit-	Mental/Behavioral Health Office Visit --------none-------- Mental/Behavioral Health Facility Visit-Facility Charges

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
		Facility Charges 10% coinsurance	Facility Charges 50% coinsurance	Coverage for Non-Network Providers is limited to $380 maximum benefit per admission.
	Mental/Behavioral health inpatient services	10% coinsurance	50% coinsurance	Coverage for Non-Network Providers is limited to $650 maximum benefit per day.
	Substance use disorder outpatient services	Substance Abuse Office Visit $20 copay per visit Substance Abuse Facility Visit -Facility Charges 10% coinsurance	Substance Abuse Office Visit 50% coinsurance Substance Abuse Facility Visit -Facility Charges 50% coinsurance	Substance Abuse Office Visit --------none-------- Substance Abuse Facility Visit -Facility Charges Coverage for Non-Network Providers is limited to $380 maximum benefit per admission.
	Substance use disorder inpatient services	10% coinsurance	50% coinsurance	Coverage for Non-Network Providers is limited to $650 maximum benefit per day.
If you are pregnant	Prenatal and postnatal care	10% coinsurance	50% coinsurance	--------none--------
	Delivery and all inpatient services	10% coinsurance	50% coinsurance	Coverage for Non-Network Providers is limited to $650 maximum benefit per day. 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	10% coinsurance	50% coinsurance	Coverage for In-Network Providers and Non-Network Providers combined is limited to 100 visits per benefit period. Coverage for Non-Network Providers is limited to $75 maximum benefit per visit.
	Rehabilitation services	$20 copay per visit	50% coinsurance	--------none--------
	Habilitation services	$20 copay per visit	50% coinsurance	--------none--------
	Skilled nursing care	10% coinsurance	50% coinsurance	Coverage for 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

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
				benefit per day.
	Durable medical equipment	10% coinsurance	50% coinsurance	--------none--------
	Hospice service	No charge	50% coinsurance	--------none--------
If your child needs dental or eye care	Eye exam	No charge	No charge	Coverage for In-Network Providers and Non-Network Providers combined is limited to 1 exam per benefit period.
	Glasses	No charge	No charge	Coverage for In-Network Providers and Non-Network Providers combined is limited to 1 unit per benefit period.
	Dental check-up	No charge	No charge	--------none--------

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.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide.
- 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
- Chiropractic care Coverage is limited to 20 visits per benefit period.
- Infertility treatment Coverage is limited to $2,000 maximum benefit per lifetime.
- Private-duty nursing Coverage is limited to 100 visits per benefit period.

Current Plan Benefits Summaries

CONTRACT TYPE: DENTAL GUARD 2000

This plan is currently offered for Insurance Class 1

PLAN BENEFITS SUMMARY		
	In-Network	**Out-of-Network**
Coinsurance		
Preventive	100%	100%
Basic	100%	80%
Major	60%	50%
Deductible	N/A	N/A
Waived for preventive?	No	No
Maximum	$2,500	$2,500
Orthodontia	Excluded	
Lifetime Maximum	N/A	
Coinsurance	N/A	
Maximum Rollover		
Threshold	$900	
Rollover Amount	$450	
In-network only rollover	$700	
Max Rollover Limit	$1,500	
Dependent Age Limit	26/26	

If your group is considered a small group, subject to ACA regulations, and you would like to consider dental plans that "wrap" around the pediatric dental benefit that may be included in your medical plan, please contact your local Sales Office for options.

Plan information is for illustrative purposes only. Please consult plan contract for specific benefit levels.

Additional Dental Information

DENTAL MAXIMUM ROLLOVER SUMMARY		
For Benefit Year Ending: 12/31/2015		
ROLLOVER ACCOUNT SIZE	**NUMBER OF QUALIFYING EMPLOYEES & DEPENDENTS**	**TOTAL ACCOUNT VALUE**
$0	13	$0.00
$1 - $250	0	$0.00
$251 - $500	0	$0.00
$501 - $750	3	$2,100.00
$751 - $1,000	0	$0.00
Over $1,000	5	$7,150.00
TOTAL	**8**	**$9,250.00**

11 of your Employees and Dependents currently are eligible for additional Maximum Rollover amounts.

"Benefit Year" refers to the 12-month period during which charges are counted toward this plan's annual maximum.

"Number of Qualifying Employees and Dependents" reflects information available at the time this renewal package was issued. Additional claims will affect this count.

"Eligibility for additional rollover amounts reflects information available at the time this renewal package was issued. Additional claims will affect the eligibility for additional rollover amounts"

Rollover amounts earned in the benefit year ending 12/31/2015 are applied to the members Maximum Rollover Account for use starting the next benefit year.

Current Plan Benefits Summaries

VSP

VISION

This plan is currently offered for Insurance Class 1

PLAN BENEFITS SUMMARY			
	In-Network	**Out-of-Network**	**Frequency**
Exam Copay	$10	$10	12 months
Exam Allowance	100%	$46	12 months
Materials Copay	$25	$25	
Base Lenses			
Single Vision Allowance	100%	$47	12 months
Bifocal Allowance	100%	$66	12 months
Trifocal Allowance	100%	$85	12 months
Lenticular Allowance	100%	$125	12 months
Contact Lenses			
Elective Allowance	$120	$120	12 months
Therapeutic Allowance	100%	$210	12 months
Frame Retail Allowance	$120	$47	24 months
Materials Allowance	N/A	N/A	N/A

Plan information is for illustrative purposes only. Please consult plan contract for specific benefit levels.

Current Plan Benefits Summaries

LONG TERM DISABILITY

This plan is currently offered for Insurance Class 1

PLAN BENEFITS SUMMARY	
Monthly Benefit	60% to $6,000
Elimination Period	90 days
Benefit Duration	To Age 67/Adea
Own Occupation Period	Own Occ/Extended Own Occ
Gainful Occupation	80%
Pre-Existing Conditions	6/24 Exclusion
Mental Nervous	2 years
Substance Abuse	2 years
Cost of Living (COLA)	N/A
Survivor Benefit	3 months
Integration	Full Family
Rehabilitation Benefit	Enhanced Rehab

Plan information is for illustrative purposes only. Please consult plan contract for specific benefit levels.

Current Plan Benefits Summaries

BASIC LIFE

This plan is currently offered for Insurance Class 1

LIFE BENEFITS SUMMARY	
Benefit Type	Flat
Multiple	N/A
Maximum Benefit	$50,000
Earnings Definition	N/A
Guarantee Issue	N/A
Waiver of Premium	Lifeassist To Age 65
Age Reduction Formula	
Age 65	50%
Accelerated Benefit	
Benefit %	N/A
Benefit Maximum	N/A

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This plan is currently offered for Insurance Class 1

AD&D BENEFITS SUMMARY	
Benefit Type	Flat
Multiple	N/A
Maximum Benefit	$50,000
Earnings Definition	N/A

Plan information is for illustrative purposes only. Please consult plan contract for specific benefit levels.