

# Your summary of benefits



Anthem Blue Cross Life and Health Insurance Company

Student Health Plan: Saint Mary's College of California

Your Plan: Custom PPO 200/10

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
<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. In-Network Providers and Non-Network Providers deductibles are combined. Satisfying one helps satisfy the other.</i>	\$200 per member	\$200 per member
<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. Network Providers and Non-Network Providers out-of-pocket limits are combined. Satisfying one helps satisfy the other.</i>	\$4,000 per member	\$4,000 per member/
<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	30% coinsurance
<b>Doctor Home and Office Services</b>		
<b>Primary care visit to treat an injury or illness</b>	10% coinsurance	30% coinsurance
<b>Specialist care visit</b>	10% coinsurance	30% coinsurance
<b>Other practitioner visits:</b>		
On-line Visit	10% coinsurance	30% coinsurance
Chiropractor services	10% coinsurance	30% coinsurance
Acupuncture	10% coinsurance	30% coinsurance

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<p><b>Other services in an office:</b></p> <ul style="list-style-type: none"> <li>Allergy testing</li> <li>Chemo/radiation therapy</li> <li>Hemodialysis</li> <li>Prescription drugs</li> </ul> <p><i>For the drugs itself dispensed in the office thru infusion/injection</i></p>	<p>0% coinsurance</p> <p>10% coinsurance</p> <p>10% coinsurance</p> <p>10% coinsurance</p>	<p>30% coinsurance</p> <p>30% coinsurance</p> <p>30% coinsurance</p> <p>30% coinsurance</p>
<p><b>Diagnostic Services</b></p> <p><b>Lab:</b></p> <p><i>Precertification required for some services.</i></p> <ul style="list-style-type: none"> <li>Office</li> <li>Freestanding Lab</li> <li>Outpatient Hospital</li> </ul>	<p>0% coinsurance</p> <p>0% coinsurance</p> <p>0% coinsurance</p>	<p>30% coinsurance</p> <p>30% coinsurance</p> <p>30% coinsurance</p>
<p><b>X-ray:</b></p> <p><i>Precertification is required for some services.</i></p> <ul style="list-style-type: none"> <li>Office</li> <li>Freestanding Radiology Center</li> <li>Outpatient Hospital</li> </ul>	<p>0% coinsurance</p> <p>0% coinsurance</p> <p>0% coinsurance</p>	<p>30% coinsurance</p> <p>30% coinsurance</p> <p>30% coinsurance</p>
<p><b>Advanced diagnostic imaging (for example, MRI/PET/CAT scans):</b></p> <p><i>Precertification is required for some services.</i></p> <ul style="list-style-type: none"> <li>Office</li> <li>Freestanding Radiology Center</li> <li>Outpatient Hospital</li> </ul>	<p>10% coinsurance</p> <p>10% coinsurance</p> <p>10% coinsurance</p>	<p>30% coinsurance</p> <p>30% coinsurance</p> <p>30% coinsurance</p>
<p><b>Emergency and Urgent Care</b></p> <p><b>Emergency room facility services</b></p> <p><i>Copay waived if admitted. This is for the hospital/facility charge only. The ER physician charge may be separate.</i></p> <p><b>Emergency room doctor and other services</b></p>	<p>\$100 copay per admission and then 10% coinsurance</p> <p>10% coinsurance</p>	<p>Covered as In-Network</p> <p>Covered as In-Network</p>

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<b>Ambulance (air and ground)</b>	10% coinsurance	Covered as In-Network
<b>Urgent Care (office setting)</b> <i>Costs may vary by site of service.</i>	10% coinsurance	30% coinsurance
<b>Outpatient Mental/Behavioral Health and Substance Abuse</b>		
<b>Doctor office visit</b> <i>Includes online visits for Behavioral Health.</i>	10% coinsurance	30% coinsurance
<b>Facility visit:</b> Facility fees	10% coinsurance	30% coinsurance
<b>Outpatient Surgery</b>		
<b>Facility fees:</b>		
Hospital <i>Precertification required.</i>	10% coinsurance	30% coinsurance
Freestanding Surgical Center <i>Precertification is required. If precertification is not obtained for non-emergency admission at an Out-of-Network Provider, additional \$500 copay applies.</i>	10% coinsurance	30% coinsurance
<b>Doctor and other services</b>	10% coinsurance	30% coinsurance
<b>Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)</b>		
<b>Facility fees (for example, room &amp; board)</b> <i>Precertification is required for some services. If precertification is not obtained for non-emergency admission at an Out-of-Network Provider, additional \$500 copay applies.</i>	10% coinsurance	30% coinsurance
<b>Doctor and other services</b>	10% coinsurance	30% coinsurance
<b>Recovery &amp; Rehabilitation</b>		
<b>Home health care</b> <i>Precertification is required. Coverage for In-Network Provider and Non-Network Provider combined is limited to 100 visit limit per benefit period.</i>	10% coinsurance	30% coinsurance

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<p><b>Rehabilitation services (for example, physical/speech/occupational therapy):</b></p> <ul style="list-style-type: none"> <li>Office</li> <li>Outpatient hospital</li> <li>Habilitation services</li> </ul>	<p>10% coinsurance</p> <p>10% coinsurance</p> <p>10% coinsurance</p>	<p>30% coinsurance</p> <p>30% coinsurance</p> <p>30% coinsurance</p>
<p><b>Cardiac rehabilitation</b></p> <ul style="list-style-type: none"> <li>Office</li> <li>Outpatient hospital</li> </ul>	<p>10% coinsurance</p> <p>10% coinsurance</p>	<p>30% coinsurance</p> <p>30% coinsurance</p>
<p><b>Skilled nursing care (in a facility)</b>  <i>Precertification is required. Coverage for In-Network Provider and Non-Network Provider combined is limited to 100 day limit per benefit period.</i></p>	<p>10% coinsurance</p>	<p>30% coinsurance</p>
<p><b>Hospice</b>  <i>Precertification is required. Deductible does not apply to In-Network providers.</i></p>	<p>No charge</p>	<p>30% coinsurance</p>
<p><b>Durable Medical Equipment</b>  <i>Hearing aids benefit available for one hearing aid per ear every three years.</i></p>	<p>10% coinsurance</p>	<p>30% coinsurance</p>
<p><b>Prosthetic Devices</b></p>	<p>10% coinsurance</p>	<p>30% coinsurance</p>
<p><b>Medical Evacuation</b>  <i>Deductible does not apply. Charges do not apply toward Out-of-Pocket Maximum. Expenses for transporting insured person back to home country for medical care and treatment limited to \$50,000; see certificate for specific details.</i></p>	<p>No charge</p>	<p>No charge</p>
<p><b>Repatriation of Remains</b>  <i>Deductible does not apply. Charges do not apply toward Out-of-Pocket Maximum. In the event of insured person's death, expenses for preparing and transporting the insured person's bodily remains back to home country limited to \$25,000; see Certificate for specific details.</i></p>	<p>No charge</p>	<p>No charge</p>

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Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Non-Network Provider
<b>Children's Vision Essential Health Benefits</b> <i>Limited to covered persons under the age of 19.</i>		
<b>Vision exam</b> <i>Includes one exam/fitting per year</i>	No charge	No charge
<b>Frames</b> <i>Includes one per year</i>	No charge	No charge
<b>Lenses</b> <i>Includes one per year</i>	No charge	No charge
<b>Elective contact lenses</b> <i>Includes one per year</i>	No charge	No charge

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use an Non-Network Provider
<b>Children's Dental Essential Health Benefits</b> <b>Diagnostic and preventive</b> <i>Limited to covered persons under the age of 19.</i>	0% coinsurance	0% coinsurance
<b>Annual Deductible for pediatric dental</b>	\$60/member	\$60/member
<b>Annual Out of Pocket Limit for pediatric dental</b>	\$1,000/member	No maximum for non-network provider
<b>Basic services</b>	50% coinsurance	50% coinsurance
<b>Major services</b>	50% coinsurance	50% coinsurance

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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>Pharmacy Deductible</b>	\$0	\$0
<b>Pharmacy Out of Pocket</b>	Combined with medical out of pocket	Combined with medical out of pocket
<b>Prescription Drug Coverage</b> <i>This plan uses a traditional Drug List. Drugs not on the list are not covered.</i>		
<b>Tier1 - Typically Generic</b> <i>Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Member pays the retail pharmacy copay plus 50% for out of network.</i>	Tier 1 - \$10 copay per prescription (retail and home delivery)	Tier 1 - \$10 copay plus 50% coinsurance up to \$250 per prescription (retail only)
<b>Tier2 - Typically Preferred / Brand</b> <i>Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Member pays the retail pharmacy copay plus 50% for out of network.</i>	Tier 2- \$20 copay per prescription (retail only) and \$40 copay per prescription (home delivery only)	Tier 2- \$20 copay plus 50% coinsurance up to \$250 per prescription (retail only)
<b>Tier3 - Typically Non-Preferred / Specialty Drugs</b> <i>Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Member pays the retail pharmacy copay plus 50% for out of network.</i>	Tier 3 - \$20 copay per prescription (retail only) and \$40 copay per prescription (home delivery only)	Tier 3- \$20 copay plus 50% coinsurance up to \$250 per prescription (retail only)
<b>Tier4 - Typically Specialty Drugs</b> <i>Covers up to a 30 day supply (retail pharmacy and home delivery program). Member pays the retail pharmacy copay plus 50% for out of network.</i>	Tier 4 - \$20 copay per prescription (retail only) and \$40 copay per prescription (home delivery only)	Tier 4 - \$20 copay plus 50% coinsurance up to \$250 per prescription (retail only)

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## Notes:

- This Summary of Benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this Summary of Benefits. This Summary of Benefits, as updated, is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care (as applicable).
- In addition to the benefits described in this summary, coverage may include additional benefits, depending upon the member's home state. The benefits provided in this summary are subject to federal and California laws. There are some states that require more generous benefits be provided to their residents, even if the master policy was not issued in their state. If the member's state has such requirements, we will adjust the benefits to meet the requirements.
- 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.
- All medical services subject to a coinsurance are also subject to the annual medical deductible.
- Annual Out-of-Pocket Maximums includes deductible, copays, coinsurance and prescription drug.
- In network and out of network deductible and out of pocket maximum are inclusive of each other.
- 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.
- Preventive Care Services includes physical exam, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunization, health education, intervention services, HIV testing) and additional preventive care for women provided for in the guidance supported by Health Resources and Service Administration.
- For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement is based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- If your plan includes out of network benefit and you use a non-network 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. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.
- Certain types of physicians may not be represented in the PPO network in the state where the member receives services. If such physician is not available in the service area, the member's copay is the same as for PPO (with and without pre-notification, if applicable). Member is responsible for applicable copays, deductibles and charges which exceed covered expense.
- Additional visits maybe authorized if medically necessary. Pre-service review must be obtained prior to receiving the additional services.

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- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- Transplants covered only when performed at Centers of Medical Excellence or Blue Distinction Centers.
- Bariatric Surgery covered only when performed at Blue Distinction Center for Specialty Care for Bariatric Surgery.
- Skilled Nursing Facility day limit does not apply to mental health and substance abuse.
- Respite Care limited to 5 consecutive days per admission.
- Freestanding Lab and Radiology Center is defined as services received in a non-hospital based facility.
- Coordination of Benefits: The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverage do not exceed 100% of the covered expense
- When using non-network pharmacy; members are responsible for in-network pharmacy copay plus 50% of the remaining prescription drug maximum allowed amount & costs in excess of the prescription drug maximum allowed amount. Members will pay upfront and submit a claim form.
- Supply limits for certain drugs may be different, go to Anthem website or call customer service.
- Certain drugs require pre-authorization approval to obtain coverage.
- For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to [https://le.anthem.com/pdf?x=CA\\_LG\\_PPO](https://le.anthem.com/pdf?x=CA_LG_PPO)
- This plan includes custom benefits that may supersede some of the information included in the Limitations and Exclusions list provided here. Please see your EOC for full details on your covered benefits.
- For additional information on this plan, please visit [sbc.anthem.com](http://sbc.anthem.com) to obtain a Summary of Benefit Coverage.

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