Anthem BlueCross

California State University, Long Beach

2017-2018 Student Health Plan

anthem.com/ca

Important notice

This is a brief description of your Student Health Plan underwritten by Anthem Blue Cross (Anthem). If you'd like more detail about your coverage and costs, you can get the complete terms in the policy or plan document online at **anthem.com/ca**. You'll be able to get a copy of the full Master Policy as soon as it's available.

66038CAMENABC 03/17

2017-2018

CSU LONG BEACH

INTERNATIONAL, AMERICAN LANGUAGE INSTITUTE AND STUDY ABROAD @ THE BEACH

STUDENT HEALTH INSURANCE PLAN

WHO IS ELIGIBLE FOR THE PLAN

Students

All International F1 and J1 visa status students or scholars enrolled on the main campus are required to purchase this insurance plan. A person who is an immigrant, permanent resident alien or U.S. Citizen is not eligible for coverage. Students must actively attend classes on campus for the first 45 consecutive days after the effective date, with the exception of school-authorized breaks. Remote courses such as home study, correspondence, and online courses do not fulfill this requirement. A once per lifetime medical withdrawal exception may be granted to students on school approved medical leave during the first 45 days of coverage. If it is determined that eligibility requirements have not been met, our only obligation is to refund premium, less any claims paid.

Visiting scholars, Short-Term Participants and **OPT Students** may enroll in the Plan on a voluntary basis. OPT students may purchase a maximum of 12 consecutive months of coverage from the OPT effective date. OPT Extension coverage is not allowed. A copy of a valid EAD is required.

Dependents

Coverage for dependents (spouse/children) is not available under this plan.

COVERAGE PERIOD

Open Enrollment

Coverage will become effective at 12:01 a.m. on the first day of the coverage period purchased. All enrollments during the open enrollment period will be backdated to the start date of the period of coverage.

Qualifying Events

Enrollments will not be accepted after the open enrollment period unless there is a qualifying event (such as involuntary loss of other coverage). Enrollment must occur within 30 days of the qualifying event and accompany proof of the qualifying event. Coverage will become effective at 12:01 a.m. on the day following the payment. Premiums will not be pro-rated for enrollments taken after the open enrollment period.

Termination Date

Coverage terminates at 12:01 a.m. on the coverage end date indicated for the period purchased. There is no continuation coverage for this plan for students who are no longer eligible. We do not send termination or renewal notices. It is the Insured Person's responsibility to renew coverage, subject to continuing eligibility, in a timely manner. Eligibility requirements must be met each time premium is paid to renew coverage. Final decisions regarding coverage effective dates are made by the insurance company.

REFUNDS

Once eligibility requirements have been met for the first 45 days of coverage, coverage will remain in force during the period for which premium has been paid, even if the student leaves school or obtains other coverage or has a change in status. Refunds will ONLY be considered during the first 45 days of coverage and ONLY for students who drop out of school or enter full time active duty military service. Approval is subject to verification that no medical claims were filed or paid during the coverage period. No other refunds will be granted. All refund requests should be sent to the University who must confirm the student status with JCB Insurance Solutions and submit the refund request on behalf of the student.

PLAN COSTS

Coverage for dependents (spouse/children) is not available under this plan.

INTERNATIONAL STUDENT COSTS

Coverage Period	Coverage Dates	Student Cost
Annual	8/10/2017 to 8/10/2018	$1,093.76
Fall	8/10/2017 to 1/10/2018	$468.76
Spring/Summer	1/10/2018 to 8/10/2018	$646.73

AMERICAN LANGUAGE INSTITUTE COSTS

Coverage Period	Coverage Dates	Student Cost
Fall IEP	8/22/2017 to 1/15/2018	$458.94
Fall Prep	10/23/2017 to 1/15/2018	$274.91
Spring IEP	1/16/2018 to 5/21/2018	$394.36
Spring Prep	4/2/2018 to 5/21/2018	$172.31
Summer IEP	5/22/2018 to 8/20/2018	$291.77
Summer Prep	7/9/2018 to 8/20/2018	$153.80

STUDY ABROAD @ THE BEACH COSTS

Coverage Period	Coverage Dates	Student Cost
Fall	8/22/2017 to 1/15/2017	$458.94
Spring	1/16/2018 to 5/21/2018	$394.36
Summer 1	5/22/2018 to 7/6/2018	$170.80
Summer 2	5/22/2018 to 8/17/2018	$282.84
Summer 3	7/9/2018 to 8/17/2018	$145.87

The cost of coverage includes insurance premium, school administrative fees and fees payable to JCB Insurance Solutions. Rates also include Emergency Travel Assistance services provided by On Call.

MEDICAL ID CARDS

The new StudentHealth app through Anthem Blue Cross gives you instant access to your CSU Long Beach benefits, ID card and much more using your mobile device. In order to access your ID card, you must use the Student Health App. From your mobile device or tablet, go to:

The App Store® or Google PlayTM and search for the StudentHealth app. Tap Register Now and follow these easy steps:

1. Enter your first name, last name, your CSULB student ID number and your date of birth (mm/dd/yyyy), and then go to the next screen. Note: If you are unable to register, re-enter what you typed into the "first name" field by trying one of these options: First name [space] middle name (ex. Joseph Jayden); first name [space] middle initial (ex. Joseph J); first name [space] middle initial with a period (ex. Joseph J.).
2. On the Credentials screen, select a username (typically firstname.lastname) or use the assigned one.
3. Create a password. A password must contain at least six characters including both a letter and a number.
4. Now you can Login with your username and new password.

Don't have a smartphone or a tablet?

Access the app using your computer's browser at

www.mobilehealthconsumer.com/studenthealth

GLOBAL EMERGENCY ASSISTANCE SERVICES

Services provided by On Call. On Call must pay and arrange all Assistance Services, these expenses are not reimbursable.

Call the Global Response Center if you experience a medical, personal, travel or safety related problem or crisis. You have a resource experienced in navigating you through any crisis and making sure you can continue your academic travels, or get home safely. On Call assists during critical emergencies like illness or injury that may result in an evacuation to a location that has adequate care. On Call can also assist with smaller problems you may not realize you have a resource for, like finding a doctor's office or connecting you with an interpreter.

Emergency Medical Evacuation	$500,000, from inadequate to adequate facility
Medical Repatriation	$500,000, when medically necessary
Return of Remains	$100,000, in the event of death
Visit by Family / Friend	Up to $12,500, when you are hospitalized for 3+ days
Return of Dependent Children	Up to $5,000, when you are hospitalized or evacuated
Emergency Return Home	Up to $5,000, in the event of family member illness/death
Bereavement Reunion	Up to $5,000, in the event of death
Political/Natural Disaster Evacuation & Return Home	$100,000 for evacuation to Safe Haven
Pre-Trip Info, Emergency Travel Arrangements, Translator/Interpreter Assistance, Emergency Travel Funds, Legal Consultation/Referral, Hour Nurse Help Line, Lost/Stolen Document Replacement, Lost Luggage Assistance.	24/7 access to assistance hotline

On Call will not be liable for any expenses resulting from:

1. More than one Emergency Medical Evacuation and/or Repatriation for any single medical condition of an Insured Person during the Policy Period.

2. Any cost or expense not expressly covered in advance and in writing by On Call and/or not arranged by them. This exception shall not apply to Emergency Medical Evacuation from remote or primitive areas when On Call cannot be contacted in advance and delay might reasonably be expected to result in loss of life or harm to the Participant.

3. Any expense incurred for Participant(s) when travelling contrary to the advice of a Qualified Medical Practitioner, or for the purpose of obtaining medical treatment or for rest and recuperation following any prior accident or illness.

4. Any expense incurred for Emergency Medical Evacuation or Repatriation if the Participant is not suffering from a Serious Medical Condition, and/or in the opinion of Our Emergency Medical Assistance Provider's physician, the Participant can be adequately treated locally, or treatment can be reasonably delayed until the Participant returns to their Country of Domicile.

5. Any expense incurred for Emergency Medical Evacuation or Repatriation where the Participant, in the opinion of the Emergency Medical Assistance Provider's physician, can travel as an ordinary passenger without a medical escort.

6. Any expense related to the Participant engaging in any form of aerial flight except as a passenger on a scheduled airline flight, as a passenger on a licensed charter fixed wing aircraft over an established route; or as a passenger travelling on a business related activity in a fixed wing aircraft owned or leased to the Subscriber unless the form of aerial flight has been declared to and accepted by On Call in writing prior to travel.

7. Any expense related to treatment performed or ordered by a non-registered practitioner not in accordance with the standard medical practice as defined in the country of treatment.

8. Any expenses incurred as a direct or indirect result of elective surgery or cosmetic surgery.

9. Any Losses incurred by Participant or the Client if Participant or they fail to follow the advice of On Call.

10. Any valid claim costs that have been increased by the Client's or the Participant's failure to follow the advice of On Call.

IMPORTANT CONTACTS

Insurance Company
Anthem Blue Cross Life and Health Insurance Company

PPO Network
To locate PPO physicians and facilities, visit the website, or call the number below. *www.anthem.com/ca*
800-888-2108

Benefits and Claims
For questions regarding benefits or claims status. *www.anthem.com/ca*
800-888-2108

Nurse Advice Line
24 hour access to free Nurse Advice
800-700-0197

Submitting a claim
To submit a paper claim, mail a completed claim form and provide a copy of the provider billing statement within 90 days.
Anthem Blue Cross Life and Health Insurance Company P.O. Box 60007 Los Angeles, CA 90060

Emergency Travel Assistance Services
Call 24/7 if you experience a medical, personal, travel or safety related problem or crisis.
Toll Free from the US and Canada: 888-226-9488
Global Phone: 603-328-1343
Email: mail@oncallinternational.com

Enrollment and Eligibility
Enroll online and find answers to most of your eligibility questions by visiting our website. *www.jcbins.com*
562-263-5180

jcb INSURANCE SOLUTIONS

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Your choice

When you choose preferred providers

You get the highest level of benefits under your health care plan when you use services from preferred providers — which are doctors and hospitals in your plan. They're also called "in-network" providers and when you use them, you're using "in-network" benefits, which give you the best value for your plan. See the charts on the following pages for your share of the cost.

How to find a preferred provider

There are a few ways to find a preferred provider:

- Look up a provider in the Provider Directory. If you need a copy of the directory, call Member Services at the number on your ID card.
- Visit **anthem.com/ca/health-insurance/provider-directory/searchcriteria**.

When you choose non-preferred providers

You can also receive covered services from non-preferred providers, which are doctors and hospitals not in your plan. But you pay more out of pocket because the benefits are "out of network." See the charts on the following pages for your share of the cost.

Note: If a preferred provider refers you for covered services to other providers, such as labs or specialists, make sure they're preferred providers so you can get in-network benefits, which give you the best value. If you use a non-preferred provider, you pay more out of pocket because your benefits are out of network even if a preferred provider refers you.

Your out-of-pocket maximum

Your out-of-pocket maximum is the most you could pay during a plan year for copays and coinsurance for covered services. See the charts on the following pages for more details.

Emergency room (ER) services

In an emergency, such as a suspected heart attack, stroke or poisoning, you should go directly to the nearest ER or call 911 (or the local emergency phone number). You pay a copay per visit for in-network or out-of-network ER services. See the charts on the following pages for your share of the cost.

Utilization review requirements

Utilization review is a process of looking at certain types of care, such as hospital admissions, to make sure they're needed, appropriate and efficient. You must follow the requirements of utilization review, including pre-admission review, pre-service approval for certain outpatient services, concurrent review and discharge planning, and individual case management. For more information about utilization review, see your plan document. If you need non-emergency or non-maternity hospitalization, you or someone on your behalf must call the number on your ID card for preapproval.

Pediatric, Vision and Dental benefits

Your medical plan includes a vision and dental policy that covers pediatric essential benefits, for members until the end of the month in which they turn 19.

Your summary of benefits

Anthem Blue Cross

Your Plan: Custom Classic PPO 150/20/10 (10%/25%)

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
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$150 student	$150 student
Out-of-Pocket Limit 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.	$6,350 student	$6,350 student
Preventive care/screening/immunization In-network preventive care is not subject to deductible, if your plan has a deductible.	No charge	25% coinsurance
Doctor Home and Office Services	$20 copay per visit	25% coinsurance
○ **Primary care visit to treat an injury or illness** *Deductible does not apply to in-network providers.*		
○ **Specialist care visit** *Deductible does not apply to in-network providers.*	$20 copay per visit	25% coinsurance
○ **Prenatal and Post-natal Care** *Deductible does not apply to in-network providers.*	$20 copay per visit	25% coinsurance
○ Other practitioner visits:		
— **Retail health clinic** *Deductible does not apply to in-network providers.*	$20 copay per visit	25% coinsurance
— **On-line Visit** *Deductible does not apply to in-network providers.*	$10 copay per visit	25% coinsurance
— **Chiropractor services** *Coverage for in-network provider and non-network provider combined is limited to 30-visit limit per benefit period. Deductible does not apply to in-network providers.*	$20 copay per visit	25% coinsurance

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Acupuncture *Coverage for in-network provider and non-network provider combined is limited to 20-visit limit per benefit period. Deductible does not apply to in-network providers.*	$20 copay per visit	25% coinsurance
∘ **Other services in an office:**		
— Allergy testing	10% coinsurance	25% coinsurance
— Chemo/radiation therapy	10% coinsurance	25% coinsurance
— Hemodialysis	10% coinsurance	25% coinsurance
— Prescription drugs *For the drugs itself dispensed in the office through infusion/injection*	10% coinsurance	25% coinsurance
Diagnostic Services ∘ **Lab:**		
— Office	10% coinsurance	25% coinsurance
— Freestanding Lab	10% coinsurance	25% coinsurance
— Outpatient Hospital *Coverage for out-of-network provider is limited*	10% coinsurance	25% coinsurance
∘ **X-ray:**		
— Office	10% coinsurance	25% coinsurance
— Freestanding Radiology Center	10% coinsurance	25% coinsurance
— Outpatient Hospital *Coverage for out-of-network provider is limited*	10% coinsurance	25% coinsurance
∘ **Advanced diagnostic imaging (for example, MRI/PET/CAT scans):**		
— Office *Coverage for out-of-network provider is limited*	10% coinsurance	25% coinsurance
— Freestanding Radiology Center *Coverage for out-of-network provider is limited*	10% coinsurance	25% coinsurance

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital *Coverage for out-of-network provider is limited*	10% coinsurance	25% coinsurance
Emergency and Urgent Care • **Emergency room facility services** *Copay waived if admitted. This is for the hospital/facility charge only. The ER physician charge may be separate. Copay waived if admitted.* • **Emergency room doctor and other services**	$150 copay per admission and then 10% coinsurance 10% coinsurance	Covered as in-network Covered as in-network
• **Ambulance (air and ground)**	10% coinsurance	Covered as in-network
• **Urgent Care (office setting)** *Deductible does not apply to in-network providers.*	$20 copay per visit	25% coinsurance
Outpatient Mental/Behavioral Health and Substance Abuse • **Doctor office visit** • **Facility visit:** — Facility fees	$20 copay per visit; deductible does not apply 10% coinsurance; after deductible is met	25% after deductible is met 25% after deductible is met
Outpatient Surgery • **Facility fees:** — Hospital *Coverage for out-of-network provider is limited* — Freestanding Surgical Center *Coverage for out-of-network provider is limited* • **Doctor and other services**	10% coinsurance 10% coinsurance 10% coinsurance	25% coinsurance 25% coinsurance 25% coinsurance

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Hospital Stay (all inpatient stays including maternity, mental/ behavioral health, and substance abuse) • **Facility fees (for example, room & board)** *Copay of $500 applies for our out-of-network providers if you do not receive pre-authorization. Coverage is limited for out-of-network providers and non-emergency admissions.* • **Doctor and other services**	10% coinsurance 10% coinsurance	25% coinsurance 25% coinsurance
Recovery & Rehabilitation • **Home health care** *Coverage for in-network provider and non-network provider combined is limited to 100-visit limit per benefit period.*	10% coinsurance	25% coinsurance
• **Rehabilitation services (for example, physical/speech/ occupational therapy):** — Office *Costs may vary by site of service.* — Outpatient hospital *Coverage for out-of-network provider is limited* — Habilitation services	10% coinsurance 10% coinsurance 10% coinsurance	25% coinsurance 25% coinsurance 25% coinsurance
• **Cardiac rehabilitation** — Office — Outpatient hospital *Coverage for out-of-network provider is limited*	10% coinsurance 10% coinsurance	25% coinsurance 25% coinsurance
Skilled nursing care (in a facility) *Coverage for in-network provider and non-network provider combined is limited to 100-day limit per benefit period.*	10% coinsurance	25% coinsurance
Hospice *Deductible does not apply to in-network providers.*	No charge	25% coinsurance
Durable Medical Equipment	10% coinsurance	25% coinsurance
Prosthetic Devices	10% coinsurance	25% coinsurance

Your summary of benefits

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Children's Vision Essential Health Benefits Limited to covered persons under age 19 o **Vision exam** – Includes one exam/fitting per year	No charge	25% coinsurance
o **Frames** – Includes one per year	No charge	25% coinsurance
o **Lens** – Includes one per year	No charge	25% coinsurance
o **Elective contact lenses** – Includes one per year	No charge	25% coinsurance

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Children's Dental Essential Health Benefits **Diagnostic and preventive** *Limited to covered persons under age 19*	No charge	No charge
Basic services	30% coinsurance	30% coinsurance
Major services	50% coinsurance	30% coinsurance
Orthodontic Care	50% coinsurance	50% coinsurance

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use SHC	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	$0	$0	$0
Pharmacy Out-of-Pocket Maximum *(Prescription drugs apply to the out-of-pocket limit)*	$0	$0	$0
Prescription Drug Coverage			
Preventive Pharmacy • **Preventive Immunization** • **Female oral contraceptive** *Generic, Single Source and Multi-Source brand*	$0 copay (retail only) $0 copay (retail only)	$0 copay (retail only) $0 copay (retail only)	50% coinsurance per prescription up to $250 maximum (retail only) 50% coinsurance per prescription up to $250 maximum (retail only)
• **Tier 1 - Typically Generic** *Covers up to a 30-day supply (retail pharmacy); Covers up to a 90-day supply (home delivery program)*	10% coinsurance per prescription up to $100 maximum (retail only)	50% coinsurance per prescription up to $100 maximum	50% coinsurance per prescription up to $250 maximum (retail only)
• **Tier 2 - Typically Preferred/Brand** *Covers up to a 30-day supply (retail pharmacy); Covers up to a 90-day supply (home delivery program)*	10% coinsurance per prescription up to $250 maximum (retail only)	50% coinsurance per prescription up to $250 maximum	50% coinsurance per prescription up to $250 maximum (retail only)
• **Tier 3 - Typically Non-Preferred/Specialty Drugs** *Certain drugs require preauthorization approval to obtain coverage. Covers up to a 30-day supply (retail pharmacy); Covers up to a 90-day supply (home delivery program)*	10% coinsurance per prescription up to $250 maximum (retail only)	50% coinsurance per prescription up to $250 maximum	50% coinsurance per prescription up to $250 maximum (retail only)
• **Tier 4 - Typically Specialty Drugs** *Classified specialty drugs must be obtained through our Specialty Pharmacy Program and are subject to the terms of the program. Limited to a 30-day supply.*	10% coinsurance per prescription up to $250 maximum (retail only)	50% coinsurance per prescription up to $250 maximum	Not covered

Your summary of benefits

Notes:

- This Summary of Benefits has been updated to comply with federal and state requirements, including applicable provisions of the 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.
- 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 include deductible, copays, coinsurance and prescription drug.
- In-network and out-of-network deductible and out-of-pocket maximum are exclusive 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 include 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.
- Non-emergency, out-of-network air ambulance services are limited to Anthem maximum payment of $50,000 per trip.
- 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.

Your summary of benefits

- Additional visits maybe authorized if medically necessary. Pre-service review must be obtained prior to receiving the additional services.
- 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 preauthorization 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**
- For additional information on this plan, please visit **sbc.anthem.com** to obtain a Summary of Benefit Coverage.