2019-2020 Student Health Plan

California State University Long Beach

Important notice

This is a brief description of your Student Health Plan underwritten by Anthem Blue Cross (Anthem). If you'd like more details 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.

Anthem®

anthem.com/ca

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 referred 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.

LiveHealth Online

LiveHealth Online lets you have a video visit with a board-certified doctor using your smartphone, tablet or computer with a webcam. No appointments, no driving and no waiting at an urgent care center. Doctors are available 24/7 to assess your condition.

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 an out-of-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.*	$6,150 student	$6,150 student
Preventive care/screening/immunization *In-network preventive care is not subject to a deductible, if your plan has a deductible.*	No charge	25% coinsurance
Doctor home and office services		
∘ **Primary care visit to treat an injury or illness** *Deductible does not apply to in-network providers.*	$20 copay per visit	25% coinsurance
∘ **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
— LiveHealth Online medical visit *Deductible does not apply to in-network providers.*	$0 copay per visit	Not applicable
— Chiropractor services *Coverage for in-network provider and out-of-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 an out-of-network provider
Acupuncture *Deductible does not apply to in-network providers.*	$20 copay per visit	25% coinsurance
∘ **Other services in an office:** — Allergy testing — Chemo/radiation therapy — Hemodialysis — Prescription drugs *For the drug itself, dispensed in the office through infusion/injection*	 10% coinsurance 10% coinsurance 10% coinsurance 10% coinsurance	 25% coinsurance 25% coinsurance 25% coinsurance 25% coinsurance
Diagnostic services ∘ **Lab:** — Office — Freestanding lab — Outpatient hospital *Coverage for out-of-network provider is limited.*	 10% coinsurance 10% coinsurance 10% coinsurance	 25% coinsurance 25% coinsurance 25% coinsurance
∘ **X-ray:** — Office — Freestanding radiology center — Outpatient hospital *Coverage for out-of-network provider is limited.*	 10% coinsurance 10% coinsurance 10% coinsurance	 25% coinsurance 25% coinsurance 25% coinsurance
∘ **Advanced diagnostic imaging (for example, MRI/PET/CAT scans):** — Office *Coverage for out-of-network provider is limited.* — Freestanding radiology center *Coverage for out-of-network provider is limited.*	 10% coinsurance 10% coinsurance	 25% coinsurance 25% coinsurance
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.* ∘ **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

Your summary of benefits

Covered medical benefits	Cost if you use an in-network provider	Cost if you use an out-of-network provider
Outpatient mental/behavioral health and substance abuse		
∘ **Doctor office visit**	$20 copay per visit; deductible does not apply	25% after deductible is met
∘ **Facility visit:** — Facility fees	10% coinsurance; after deductible is met	25% after deductible is met
Outpatient surgery		
∘ **Facility fees:**		
— Hospital *Coverage for out-of-network provider is limited.*	10% coinsurance	25% coinsurance
— Freestanding surgical center *Coverage for out-of-network provider is limited.*	10% coinsurance	25% coinsurance
∘ **Doctor and other services**	10% coinsurance	25% coinsurance
Hospital stay (all inpatient stays including maternity, mental/behavioral health, and substance abuse)		
∘ **Facility fees (for example, room and 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.*	10% coinsurance	25% coinsurance
∘ **Doctor and other services**	10% coinsurance	25% coinsurance
Recovery and rehabilitation		
∘ **Home health care** *Coverage for in-network provider and out-of-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.*	10% coinsurance	25% coinsurance
— Outpatient hospital *Coverage for out-of-network provider is limited.*	10% coinsurance	25% coinsurance
— Habilitation services	10% coinsurance	25% coinsurance
∘ **Cardiac rehabilitation**		
— Office	10% coinsurance	25% coinsurance
— Outpatient hospital *Coverage for out-of-network provider is limited.*	10% coinsurance	25% coinsurance
Skilled nursing care (in a facility) *Coverage for in-network provider and out-of-network provider combined is limited to 100-day limit per benefit period.*	10% coinsurance	25% coinsurance

Your summary of benefits

Covered medical benefits	Cost if you use an in-network provider	Cost if you use an out-of-network provider
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 an out-of-network provider
Children's vision essential health benefits *Limited to covered persons under age 19* • **Vision exam** — Includes one exam/fitting per year	No charge	25% coinsurance
• **Frames** — Includes one per year	No charge	25% coinsurance
• **Lens** — Includes one per year	No charge	25% coinsurance
• **Elective contact lenses** — Includes one per year	No charge	25% coinsurance

Covered dental benefits — individual deductible $100 and out-of-pocket maximum of $1,000	Cost if you use an in-network provider	Cost if you use an out-of-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 an out-of-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**	$0 copay (retail only)	$0 copay (retail only)	50% coinsurance per prescription, up to $250 maximum (retail only)
• **Female oral contraceptive** *Generic, single-source and multi-source brand*	$0 copay (retail only)	$0 copay (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.
- 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 (for example, 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 out-of-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.
- Additional visits may be 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.

Your summary of benefits

- Skilled nursing facility day limit does not apply to mental health and substance abuse.
- Respite care limited to five 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 an out-of-network pharmacy, members are responsible for in-network pharmacy copay, plus 50% of the remaining prescription drug maximum allowed amount and 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's 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*.