Your summary of benefits

Anthem BlueCross

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Your Plan: Classic Prudent Buyer Incentive PPO

Your Network: National PPO (Blue Card 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.* ***Additional deductible:*** *50% per admission Non-Anthem Blue Cross PPO hospital or residential treatment center if utilization review not obtained (waived for emergency admission) $100 per admission Emergency room services $500 per admission Non-Anthem Blue Cross PPO hospital or residential treatment center (waived for emergency admission)*	$500 single / $1,500 family	$1,000 single / $3,000 family
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.*	$3,500 single / $10,500 family	$5,500 single
Doctor Home and Office Services		
Preventive care/screening/immunization		
Routine physical exams *(birth through age 18)*	No copay (deductible waived).	40% coinsurance
Immunizations, diagnostic x-ray & lab for routine physical exams *(birth through age 18)*	No copay (deductible waived).	40% coinsurance (benefit limited to $150/calendar year)
Routine physical exams, immunizations, diagnostic X-ray & lab for routine physical exam *(members 19 and older)*	No copay (deductible waived).	Not covered
Adult preventive services *(including mammograms, pap smears ,prostate cancer screenings & colorectal cancer screenings)*	No copay (deductible waived).	40% coinsurance
Primary care visit to treat an injury or illness	$25 copay per visit	40% coinsurance

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	(deductible waived)	
Specialist care visit	$40 copay per visit (deductible waived)	40% coinsurance
Pregnancy & Maternity Care		
Physician office visit	$25 copay per visit (deductible waved)	40% coinsurance
Normal delivery, cesarean section, complications of pregnancy & abortion. Refer to physician & hospital medical services benefits for both inpatient and outpatient hospital coverage.	20% coinsurance	40% coinsurance
Other practitioner visits:		
Retail health clinic	$25 copay per visit (deductible waived)	40% coinsurance
On-line Visit	$10 copay per visit (deductible waived)	40% coinsurance
Pinal Manipulation *(limited to 24 visits/calendar year. Combined with physical therapy and occupational therapy).*	20% coinsurance	40% coinsurance
Speech Therapy	20% coinsurance	40% coinsurance
Acupuncture	20% coinsurance	40% coinsurance
Other services in an office:		
Allergy testing	20% coinsurance	40% coinsurance
Chemo/radiation therapy	20% coinsurance	40% coinsurance
Diabetes Education Program	$25 copay per visit (deductible waived)	40% coinsurance
Hemodialysis	20% coinsurance	40% coinsurance
Prescription drugs *For the drugs itself dispensed in the office thru infusion/injection*	20% coinsurance	40% coinsurance
Diagnostic Services		
Lab:		
Office	20% coinsurance	40% coinsurance
Freestanding Lab	20% coinsurance	40% coinsurance

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Outpatient Hospital	20% coinsurance	40% coinsurance
X-ray:		
Office	20% coinsurance	40% coinsurance
Freestanding Radiology Center	20% coinsurance	40% coinsurance
Outpatient Hospital	20% coinsurance	40% coinsurance
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office *(Subject to utilization review).*	20% coinsurance	40% coinsurance
Freestanding Radiology Center	20% coinsurance	40% coinsurance
Outpatient Hospital	20% coinsurance	40% coinsurance
Emergency and Urgent Care **Emergency room facility services**	$100 ER Deductible/visit + 20% coinsurance	$100 ER Deductible/visit + 20% coinsurance
Emergency room doctor and other services	20% coinsurance	20% coinsurance
Ambulance (air and ground) *(air ambulance in a non-medical emergency is subject to pre-service review and benefit limited to $50,000 for non-PPO)*	20% coinsurance	In an emergency or with an authorized referral: 20% coinsurance Non-emergency: 40% coinsurance.
Urgent Care	$25 copay per visit (deductible waived)	40% coinsurance
Outpatient Mental/Behavioral Health and Substance Abuse **Doctor office visit**	$25 copay per visit (deductible waived)	40% coinsurance
Facility visit:		
Facility fees	20% coinsurance	40% coinsurance
Outpatient Surgery		

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Facility fees:		
Hospital	20% coinsurance	40% coinsurance
Freestanding Surgical Center *(Subject to utilization review for certain outpatient services; waived for emergency admissions).*	20% coinsurance	40% coinsurance (benefit limited to $350/admit)
Doctor and other services	20% coinsurance	40% coinsurance
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)		
Facility fees (for example, room & board) *(Subject to utilization review for inpatient services; waived for emergency admissions).*	20% coinsurance	40% coinsurance
Doctor and other services	20% coinsurance	40% coinsurance
Recovery & Rehabilitation		
Home health care *(Subject to utilization review). (limited to 120 visits/calendar year, one visit by a home health aide equals four hours or less).*	20% coinsurance	40% coinsurance
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *(limited to 24 visits/calendar year. For physical therapy, occupational therapy, and spinal manipulation combined)*	20% coinsurance	40% coinsurance
Outpatient hospital	20% coinsurance	40% coinsurance
Habilitation services	20% coinsurance	40% coinsurance
Cardiac rehabilitation		
Office	20% coinsurance	40% coinsurance
Outpatient hospital	20% coinsurance	40% coinsurance
Skilled nursing care (in a facility) *(Subject to utilization review). (limited to 120 days/calendar year; limit does not apply to mental health and substance abuse).*	20% coinsurance	40% coinsurance

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Hospice	20% coinsurance	40% coinsurance
Durable Medical Equipment *(May be subject to utilization review). (hearing aids one pair every 3 years; breast pump and supplies are covered under preventive care at no charge for in-network).*	20% coinsurance	40% coinsurance
Prosthetic Devices	20% coinsurance	40% coinsurance
Home Infusion Therapy *(subject to utilization review)*	20% coinsurance	40% coinsurance
Bariatric Surgery *Subject to utilization review ; covered only when performed at a Centers of Medical Excellence [CME]for California; Blue Distinction Centers of Specialty Care [BDCSC] for out of California*		
Inpatient Services provided in connection with medically necessary surgery for weight loss, only for morbid obesity	20% coinsurance	Not covered
Travel expenses for an authorized, specified surgery *(recipient & companion transportation limited to $3,000 per surgery)*	No copay (after deductible)	Not covered
Organ & Tissue Transplants *Subject to utilization review; specified transplants covered only when preformed at Centers of Medical Excellence [CME] for California; Blue Distinction Centers of Specialty Care [BDCSC] and CME for out of California*		
Inpatient Services provided in connection with non-investigative organ or tissue transplant	20% coinsurance	Not covered
Transplant travel expense for an authorized, specified transplant *(recipient and companion transportation limited to $10,000 per transplant)*	No copay (after deductible)	Not covered
Unrelated donor search, limited to $30,000 per transplant		

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Notes:

- Additional visits maybe authorized if medically necessary. Pre-service review must be obtained prior to receiving the additional services.
- 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.
- Applied behavior analysis treatment for autism spectrum disorder is covered according to state law.
- Bariatric Surgery covered only when performed at Blue Distinction Center for Specialty Care for Bariatric Surgery.
- 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. Member is responsible for applicable copays, deductibles and charges which exceed covered expense.
- 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.
- For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to Anthem website or call customer service.
- 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.
- 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.
- 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.
- 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).
- When using Non-PPO and Other Health Care Providers, members are responsible for any difference between the covered expense '&' actual charges, as well as any deductible '&' percentage copay