Your summary of benefits

Anthem BlueCross

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Your Plan: Modified Premier PPO 500/20/20 (RX $5/$15/$25/$45/30%)

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. In-Network Providers and Non-Network Providers deductibles are combined. Satisfying one helps satisfy the other.*	$500 single / $1,000 family	$500 single / $1,000 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 / $7,000 family	$10,500 single / $21,000 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	40% 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	40% coinsurance
Specialist care visit *Deductible does not apply to In-Network providers.*	$20 copay per visit	40% coinsurance
Prenatal and Post-natal Care *Deductible does not apply to In-Network providers.*	$20 copay per visit	40% coinsurance
Other practitioner visits:		
Retail health clinic *Deductible does not apply to In-Network providers.*	$20 copay per visit	40% coinsurance
On-line Visit *Deductible does not apply to In-Network providers.*	$10 copay per visit	40% coinsurance

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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	40% coinsurance
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	40% coinsurance
Other services in an office:		
Allergy testing	20% coinsurance	40% coinsurance
Chemo/radiation therapy	20% coinsurance	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
Outpatient Hospital *Coverage for Out-of-Network Provider is limited to $350 maximum per visit.*	20% coinsurance	40% coinsurance
X-ray:		
Office	20% coinsurance	40% coinsurance
Freestanding Radiology Center	20% coinsurance	40% coinsurance
Outpatient Hospital *Coverage for Out-of-Network Provider is limited to $350 maximum per visit.*	20% coinsurance	40% coinsurance

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office *Coverage for Out-of-Network Provider is limited to $800 maximum per test.*	20% coinsurance	40% coinsurance
Freestanding Radiology Center *Coverage for Out-of-Network Provider is limited to $800 maximum per test.*	20% coinsurance	40% coinsurance
Outpatient Hospital *Coverage for Out-of-Network Provider is limited to $800 maximum per test.*	20% coinsurance	40% 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.*	$100 copay per admission and then 20% coinsurance	Covered as In-Network
Emergency room doctor and other services	20% coinsurance	Covered as In-Network
Ambulance (air and ground)	20% coinsurance	Covered as In-Network
Urgent Care (office setting) *Deductible does not apply to In-Network providers.*	$20 copay per visit	40% coinsurance
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit	$20 copay per visit deductible does not apply	40% after deductible is met.
Facility visit:		
Facility fees	20% coinsurance; after deductible is met.	40% after deductible is met.

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Outpatient Surgery		
Facility fees:		
Hospital *Coverage for Out-of-Network Provider is limited to $350 maximum per visit.*	20% coinsurance	40% coinsurance
Freestanding Surgical Center *Coverage for Out-of-Network Provider is limited to $350 maximum per visit.*	20% coinsurance	40% coinsurance
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) *Co-pay $500 if you do not receive preauthorization. Coverage is limited to $1,000 maximum per day. Apply to Out-of-Network Provider. Apply to non-emergency admission.*	20% coinsurance	40% coinsurance
Doctor and other services	20% coinsurance	40% 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.*	20% coinsurance	40% coinsurance
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Costs may vary by site of service. Deductible does not apply to In-Network providers.*	20% coinsurance	40% coinsurance
Outpatient hospital *Coverage for Out-of-Network Provider is limited to $350 maximum per visit.*	20% coinsurance	40% coinsurance
Habilitation services	20% coinsurance	40% coinsurance

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Cardiac rehabilitation		
Office	20% coinsurance	40% coinsurance
Outpatient hospital *Coverage for Out-of-Network Provider is limited to $350 maximum per visit.*	20% coinsurance	40% 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.*	20% coinsurance	40% coinsurance
Hospice *Deductible does not apply to In-Network providers.*	No charge	40% coinsurance
Durable Medical Equipment	20% coinsurance	40% coinsurance
Prosthetic Devices	20% coinsurance	40% 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
Pharmacy Deductible	$0	$0
Pharmacy Out of Pocket	Combined with medical out of pocket	Combined with medical out of pocket
Prescription Drug Coverage *This plan uses a National Drug List. Drugs not on the list are not covered.*		
Tier1 - Typically Generic *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.*	Tier1a - Typically Lower Cost Generic $5 copay per prescription (retail only) and $12.50 copay per prescription (home delivery only) Tier1b- Typically Generic $15 copay per prescription (retail only) and $37.50 copay per prescription (home delivery only).	Tier 1a 50% coinsurance up to $250 per prescription (retail only) Tier 1b 50% coinsurance up to $250 per prescription (retail only).
Tier2 - Typically Preferred / Brand *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.*	Tier 2- Typically Preferred Brand & non-preferred generic drugs $25 copay per prescription (retail only) and $75 copay per prescription (home delivery only).	Tier 2- 50% coinsurance up to $250 per prescription (retail only).

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Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Tier3 - Typically Non-Preferred / Specialty Drugs *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.*	Tier 3 - Typically Non-Preferred Brand and generic drugs $45 copay per prescription (retail only) and $135 copay per prescription (home delivery only).	Tier 3- 50% coinsurance up to $250 per prescription (retail only).
Tier4 - Typically Specialty Drugs *Classified specialty drugs must be obtained through our Specialty Pharmacy Program and are subject to the terms of the program. 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.*	Tier 4 - Typically Specialty (brand and generic) 30% coinsurance up to $250 per prescription (retail and home delivery).	Tier 4- 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 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 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.
- 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 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.
- Preferred Generic Program: If a member requests a brand name drug when a generic drug version exists, the member pays the generic drug copay plus the difference in cost between the prescription drug maximum allowed amount for the generic drug and the brand name drug dispensed, but not more than 50% of our average cost of that type of prescription drug. The Preferred Generic Program does not apply when the physician has specified "dispense as written" (DAW) or when it has been determined that the brand name drug is medically necessary for the member. In such case, the applicable copay for the dispensed drug will apply.
- 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
- For additional information on this plan, please visit sbc.anthem.com to obtain a Summary of Benefit Coverage.