Your summary of benefits

Anthem BlueCross

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Your Plan: HDHP Advantage Plus

Your Network: National PPO (BlueCard 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 Summary Plan Description (SPD). If there is a difference between this summary and the Summary Plan Description (SPD), the Summary Plan Description (SPD), 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. Pharmacy deductible is combined with medical deductible.*	$1,500 single / $3,000 family	$4,500 single / $9,000 family
NOTE: Medical coinsurance and pharmacy copays do not apply until the deductible is satisfied.		
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. Pharmacy out-of-pocket is combined with medical out-of-pocket.*	$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	20% coinsurance	40% coinsurance
Specialist care visit	20% coinsurance	40% coinsurance
Prenatal and Post-natal Care	20% coinsurance	40% coinsurance
Infertility *Covered for services to diagnose infertility only; treatment of infertility is not covered Treatment for underlying medical conditions are covered as medical*	Covered - At the benefit level of the services billed	Covered - At the benefit level of the services billed
Other practitioner visits:		
Retail health clinic	20% coinsurance	40% coinsurance
On-line Visit (LiveHealth Online) *A $59 copay per visit will be charged for medical visits prior to meeting your annual deductible. After deductible is met, coinsurance applies.*	20% coinsurance	Not Covered

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Chiropractor services *Coverage for In-Network Provider and Non-Network Provider combined is limited to 24 visit limit per benefit period.*	20% coinsurance	40% coinsurance
Acupuncture *Coverage for In-Network Provider and Non-Network Provider combined is limited to 24 visit limit per benefit period.*	20% coinsurance	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
Diagnostic Services		
Lab:	20% coinsurance	40% coinsurance
X-ray:	20% coinsurance	40% coinsurance
Advanced diagnostic imaging (for example, MRI/MRA/CAT scans):	20% coinsurance	40% coinsurance
Emergency Room		
Institutional	20% coinsurance	Covered - At the INN benefit level
Physician	20% coinsurance	Covered - At the INN benefit level
Ambulance (air and ground)	20% coinsurance	Covered as In-Network
Urgent Care (Institutional/Outpatient Professional/Office Professional)	20% coinsurance	40% coinsurance
Mental Health		
Inpatient Institutional	20% coinsurance	40% coinsurance
Residential Treatment Centers-Inpatient	20% coinsurance	40% coinsurance
Outpatient Institutional	20% coinsurance	40% coinsurance

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Outpatient Surgery		
Facility fees:	20% coinsurance	40% coinsurance
Hospital	20% coinsurance	40% coinsurance
Freestanding Surgical Center	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.*	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): *Coverage for In-Network Provider and Non-Network Provider combined is limited to 24 visit limit per benefit period, per therapy.*		
Office *Costs may vary by site of service.*	20% coinsurance	40% coinsurance
Outpatient hospital	20% coinsurance	40% coinsurance
Cardiac rehabilitation		
Office	20% coinsurance	40% coinsurance
Outpatient hospital *Limit 36 visits per year.*	20% coinsurance	40% coinsurance
Skilled nursing care *Coverage for In-Network Provider and Non-Network Provider combined is limited to 120 day limit per benefit period.*	20% coinsurance	40% coinsurance
Hospice	20% coinsurance	40% coinsurance

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Durable Medical Equipment *Hearing Aids: 1 per ear, every 3 years. Other items limited to a single purchase 1 every 3 years.*	20% coinsurance	60% coinsurance
Prescriptions –Retail *(31 day supply)* Generic Formulary Non-Formulary ***For medications on the Preventative Plus list, deductible is waived and only copay applies. All other medications not on the Preventive Plus list, the member pays the full amount of the prescription while satisfying the annual deductible.*	 $10 copay* $30 copay* $60 copay*	 50% coinsurance after deductible for all tiers
Prescriptions –Mail Order *(90 day supply)* Generic Formulary Non-Formulary ***For medications on the Preventative Plus list, deductible is waived and only copay applies. All other medications not on the Preventive Plus list, the member pays the full amount of the prescription while satisfying the annual deductible.*	 $20 copay* $60 copay* $120 copay*	 Not Covered
Prescriptions – Specialty** Tier 1 Tier 2 Tier 3 *** Specialty Drugs must be filled through IngenioRx specialty pharmacy. Only one refill allowed at retail pharmacy.*	 $75/prescription $150/prescription $300/prescription	 Not Covered Not Covered Not Covered

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.
- For subscribers with dependents, this plan contains a non-embedded deductible and a non-embedded out-of-pocket. This means that the family amount can be satisfied by one family member or a combination of family members.
- Pharmacy deductible and pharmacy out of pocket is combined with medical deductible and out-of-pocket.
- This plan is an innovative type of coverage that allows a member to use a Health Savings Account to pay for medical care. The member can spend the money in the HSA account the way the member wants on medical care, prescription drugs and other qualified medical expenses. There are no copays or deductibles to satisfy first. Unused dollars can be saved from year to year to reduce the amount the member may have to pay in the future. If covered expenses exceed the member's available HSA dollars, the traditional health coverage is available after a limited out-of-pocket amount is paid by the member.
- 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 exclusive of each other.
- 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 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
- 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_CDHP
- For additional information on this plan, please visit sbc.anthem.com to obtain a Summary of Benefit Coverage.