Your summary of benefits

Anthem BlueCross

Anthem Blue Cross Life and Health Insurance — San Benito County

Your Plan: Anthem HDHP PPO (LHSA500)

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.*	$1,300 single / $2,600 family	$2,600 single / $7,800 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.*	$4,000 single / $8,000 family	$8,000 single / $16,000 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	30% coinsurance
Doctor Home and Office Services		
Primary care visit to treat an injury or illness	$25 copay per visit	30% coinsurance
Specialist care visit	$25 copay per visit	30% coinsurance
Prenatal and Post-natal Care	$25 copay per visit	30% coinsurance
Other practitioner visits:		
Retail health clinic	$25 copay per visit	30% coinsurance
On-line Visit	$25 copay per visit	30% coinsurance
Chiropractor services *Coverage for In-Network Provider for Chiropractor services and Acupuncture combined is limited to 26 visit limit per calendar year.*	10% coinsurance	30% coinsurance
Acupuncture *Coverage for In-Network Provider for Chiropractor services and Acupuncture combined is limited to 26 visit limit per calendar year.*	10% coinsurance	30% coinsurance

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Other services in an office:		
Allergy testing	10% coinsurance	30% coinsurance
Chemo/radiation therapy	10% coinsurance	30% coinsurance
Hemodialysis	10% coinsurance	30% coinsurance
Prescription drugs *For the drugs itself dispensed in the office thru infusion/injection*	10% coinsurance	30% coinsurance
Diagnostic Services		
Lab:		
Office	$25 copay per visit	30% coinsurance
Freestanding Lab	$25 copay per visit	30% coinsurance
Outpatient Hospital	$25 copay per visit	30% coinsurance
X-ray:		
Office	$25 copay per visit	30% coinsurance
Freestanding Radiology Center	$25 copay per visit	30% coinsurance
Outpatient Hospital	$25 copay per visit	30% coinsurance
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office	$25 copay per visit	30% coinsurance
Freestanding Radiology Center	$25 copay per visit	30% coinsurance
Outpatient Hospital	$25 copay per visit	30% coinsurance
Emergency and Urgent Care		
Emergency room facility services	10% coinsurance	Covered as In-Network
Emergency room doctor and other services	10% coinsurance	Covered as In-Network
Ambulance (air and ground)	10% coinsurance	Covered as In-Network

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Urgent Care (office setting)	10% coinsurance	30% coinsurance
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit	$25 copay per visit for non-preventive visit; after deductible is met.	30% coinsurance
Facility visit:		
Facility fees	10% for non-preventive visit; after deductible is met.	30% coinsurance
Outpatient Surgery		
Facility fees:		
Hospital	$250/admission	30% coinsurance
Freestanding Surgical Center	$250/admission	30% coinsurance
Doctor and other services	10% coinsurance	30% coinsurance
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)		
Facility fees (for example, room & board)	$250/day up to 3 days	30% coinsurance
Doctor and other services	10% coinsurance	30% 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	30% coinsurance
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office	10% coinsurance	30% coinsurance
Outpatient hospital	10% coinsurance	30% coinsurance

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Habilitation services Office and Outpatient hospital	10% coinsurance	30% coinsurance
Cardiac rehabilitation Office Outpatient hospital	 10% coinsurance 10% coinsurance	 30% coinsurance 30% 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	30% coinsurance
Hospice	10% coinsurance	30% coinsurance
Durable Medical Equipment	10% coinsurance	30% coinsurance
Prosthetic Devices	10% coinsurance	30% 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	Combined with medical deductible	Combined with medical deductible
Pharmacy Out of Pocket	Combined with medical out of pocket	Combined with medical out of pocket
Preventive Pharmacy *Preventive Rx Plus*	No charge (retail only)	Not covered
Prescription Drug Coverage *This plan uses an Essential formulary List. Drugs not on the list are not covered. You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days.*		
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 for retail fills that exceed 30 days.*	Tier1 - $15 copay per prescription (retail only) and $30 copay per prescription (home delivery only)	Not covered
Tier2 - Typically Preferred / Brand *Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program)*	Tier 2- Typically Preferred Brand & non-preferred generic drugs $25 copay per prescription (retail only) and $50 copay per prescription (home delivery only).	Not covered
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)*	Tier 3 - Typically Non-Preferred Brand and generic drugs $35 copay per prescription (retail only) and $70 copay per prescription	Not covered

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
	(home delivery 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 specialty pharmacy drugs) and up to a 90 day supply (home delivery program)*	Tier 4 - Typically Specialty (brand and generic) 30% coinsurance up to $150 per prescription (retail and home delivery).	Not covered

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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 out-of-pocket maximum is embedded meaning the cost shares of one family member will be applied to the individual out-of-pocket maximum; in addition, amounts for all family members apply to the family out-of-pocket maximum. No one member will pay more than the individual out-of-pocket maximum.
- The family deductible is non-embedded meaning the cost shares of all family members apply to one shared family deductible. The individual deductible only applies to individuals enrolled under single coverage.
- Pharmacy deductible and pharmacy out of pocket is combined with medical deductible and out-of-pocket.
- This Lumenos 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 copay or 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 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
- 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.