Your summary of benefits

Anthem

Anthem Blue Cross

Your Plan: CNB-HDHP with HSA

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.* *(applicable to medical care & prescription drug benefits; family deductible includes employee & one or more enrolled family members, no coverage may be paid for any family member unless the family deductible is met)*	$1,800 single / $3,600 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.* *(In-network/ out-of-network out-of-pocket maximums are inclusive of each other; includes calendar year deductible & prescription drug maximum allowed amounts; The single out-of-pocket only applies to individuals enrolled on single coverage; All members on Family coverage [employee and at least one dependent] must satisfy the family deductible.) See notes section for additional information regarding your out-of-pocket maximum.*	$4,500 single / $9,000 family	
Doctor Home and Office Services **Preventive care/screening/immunization** *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	40% coinsurance
Primary care visit to treat an injury or illness (in-person, virtual, or telephonic visit)	20% coinsurance	40% coinsurance
Specialist care visit (in-person, virtual, telephonic visit)	20% coinsurance	40% coinsurance

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Pregnancy & Maternity Care		
Physician office visit (in-person, virtual, or telephonic visit)	20% coinsurance	40% coinsurance
Normal delivery, cesarean section, complications of pregnancy & abortion. *(Normal routine nursery care covered when natural mother is insured employee or spouse/domestic partner).*	20% coinsurance	40% coinsurance
Other practitioner visits:		
Retail health clinic	20% coinsurance	40% coinsurance
LiveHealth Online Telemedicine Visit	$10 copay after deductible	Not covered
Spinal Manipulation *Limited to 24 visit limit per calendar year*	20% coinsurance	40% coinsurance
Speech Therapy	20% coinsurance	40% coinsurance
Acupuncture *Limited to 12 visit limit per calendar year.*	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	20% coinsurance	40% coinsurance
Hemodialysis	20% coinsurance	40% coinsurance benefit limited to $350/visit for free standing Hemodialysis center.
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	20% coinsurance	40% coinsurance

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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): *Subject to utilization review. Coverage for Out-of-network provider is limited to $800 maximum per procedure.*		
Office	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	20% coinsurance	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)*	20% coinsurance	In an emergency or with an authorized referral: 20% coinsurance, Non-emergency 40% coinsurance.
Urgent Care (facility setting)		
Facility fees	20% coinsurance	40% coinsurance
Doctor and other services	20% coinsurance	40% coinsurance
Urgent Care (Walk in Office)		
Primary care visit	20% coinsurance	40% coinsurance
Specialist care visit	20% coinsurance	40% coinsurance

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Outpatient Mental/Behavioral Health and Substance Use Disorder	20% coinsurance	40% coinsurance
Doctor office visit (in person, virtual, or telephonic visit)	20% coinsurance	40% coinsurance
Facility visit: **Facility fees and Outpatient Facility Professional fees**		
Outpatient Surgery		
Facility fees:		
Hospital *Subject to utilization review for certain outpatient services; waived for emergency admissions.*	20% coinsurance	40% coinsurance
Freestanding Surgical Center	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 Use Disorder)		
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 *Coverage for In-Network Provider and Non-Network Provider combined is limited to 100 visit limit per benefit period. Subject to utilization review.*	20% coinsurance	40% coinsurance
Rehabilitation services (for example, physical and occupational therapy):		
Office (in person, virtual, or telephonic visit) *Physical Therapy and Occupational Therapy outpatient services limited to a combined 50 visits/calendar year; In-Network Provider and Non-Network Provider combined.*	20% coinsurance	40% coinsurance
Outpatient hospital	20% coinsurance	40% coinsurance

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Coverage for Out-of-Network Provider is limited to $350 maximum per admission. Habilitation services	20% coinsurance	40% coinsurance
Cardiac rehabilitation Office Outpatient hospital *Coverage for Out-of-Network Provider is limited to $350 maximum per admission.*	20% coinsurance 20% coinsurance	40% 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. Subject to utilization review.*	20% coinsurance	40% coinsurance
Hospice	20% coinsurance	40% coinsurance
Durable Medical Equipment *May be subject to utilization review.*	20% coinsurance	40% coinsurance
Prosthetic Devices	20% coinsurance	40% coinsurance
Home Infusion Therapy *Subject to utilization review*	20% coinsurance	40% coinsurance
Bariatric Surgery & Travel Expense Benefits *Subject to utilization review* Inpatient Services provided in connection with medically necessary surgery for weight loss, only for morbid obesity. Travel expense benefit of up to $3,000 per covered treatment or procedure when an In Network provider is not available within 75 miles of member's residence - includes Bariatric surgery and all other covered procedures other than separate Organ & Tissue Transplant travel benefit noted below (recipient & companion transportation).	20% coinsurance Covered (after deductible)	Not covered Not covered

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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)*	Covered (after deductible)	Not covered
Unrelated donor search, limited to $30,000 per transplant	20% coinsurance	Not covered
Infertility		
Medical Benefit Lifetime Maximum of $15,000	20% coinsurance	40% coinsurance
Coverage includes Artificial Insemination, Invitro Fertilization (including GIFT/ZIFT)		

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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).
- The single Out of Pocket Deductible only applies to individuals enrolled under single coverage. For all members on Family coverage (employee and at least one dependent) the Family Deductible must be satisfied before any family member can be considered as having satisfied their Deductible..
- The single Out of Pocket Maximum only applies to individuals enrolled under single coverage. For all members on Family coverage (employee and at least one dependent) the Family Out of Pocket Maximum must be satisfied before any family member can be considered as having satisfied their Out-of-Pocket Maximum.
- Pharmacy deductible and pharmacy out of pocket is combined with medical deductible and out-of-pocket.
- This High Deductible 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 satisfied.
- 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 drugs.
- 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-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.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.

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- Transplants covered only when performed at Centers of Medical Excellence or Blue Distinction Centers.
- 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
- For additional information on this plan, please visit sbc.anthem.com to obtain a Summary of Benefit Coverage.