# Your summary of benefits

Anthem

Anthem Blue Cross

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<br>See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.<br><br>*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<br>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. | $3,750 single / $7,500 family | $5,750 single |
| Doctor Home and Office Services | | |
| Preventive care/screening/immunization | No copay (deductible waived). | 40% coinsurance |
| Routine physical exams (birth through age 18) | No copay (deductible waived). | 40% coinsurance (benefit limited to $150/calendar year) |
| Immunizations, diagnostic x-ray & lab for routine physical exams (birth through age 18) | No copay (deductible waived). | Not covered |
| Routine physical exams, immunizations, diagnostic X-ray & lab for routine physical exam (members 19 and older) | No copay (deductible waived). | 40% coinsurance |
| Adult preventive services (including mammograms, pap smears, prostate cancer screenings & colorectal cancer screenings) | | |
| Primary care visit to treat an injury or illness<br>(in-person, virtual or telephonic visit) | $25 copay per visit (deductible waived) | 40% coinsurance |

# Your summary of benefits

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|
| Specialist care visit<br>(in-person, virtual or telephonic visit) | $40 copay per visit (deductible waived) | 40% coinsurance |
| Pregnancy & Maternity Care<br>Physician office visit<br>(in-person, virtual or telephonic 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:<br>Retail health clinic | $25 copay per visit (deductible waived) | 40% coinsurance |
| LiveHealth Online Telemedicine Visit | $10 copay per visit (deductible waived) | Not Covered |
| Spinal Manipulation<br>(limited to 24 visits/calendar year) | 20% coinsurance | 40% coinsurance |
| Speech Therapy | 20% coinsurance | 40% coinsurance |
| Acupuncture | 20% coinsurance | 40% coinsurance |
| Other services in an office:<br>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<br>For the drugs itself dispensed in the office thru infusion/injection | 20% coinsurance | 40% coinsurance |
| Diagnostic Services<br>Lab:<br>Office | 20% coinsurance | 40% coinsurance |
| Freestanding Lab | 20% coinsurance | 40% coinsurance |

# Your summary of benefits

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|
| 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 | $150 ER Deductible/visit + 20% coinsurance | $150 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 | $40 copay per visit (deductible waived) | 40% coinsurance |
| Outpatient Mental/Behavioral Health and Substance Use Disorder | | |
| Doctor office visit (in-person, virtual or telephonic visit) | $25 copay per visit (deductible waived) | 40% coinsurance |
| Facility visit: Facility fees and Outpatient Facility Professional fees | 20% coinsurance | 40% coinsurance |

# Your summary of benefits

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|
| Outpatient Surgery | | |
| Facility fees: | | |
| Hospital | 20% coinsurance | 40% coinsurance |
| Freestanding Surgical Center<br>(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 Use Disorder) | | |
| Facility fees (for example, room & board)<br>(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<br>(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 and occupational therapy): | | |
| Office (*in-person, virtual or telephonic visit*)<br>*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 |
| 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)<br>(Subject to utilization review). Limited to 120 days/calendar year; limit does not apply to mental health and Substance Use Disorder. | 20% coinsurance | 40% coinsurance |

# Your summary of benefits

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|
| Hospice | 20% coinsurance | 40% coinsurance |
| Durable Medical Equipment<br>(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<br>(subject to utilization review) | 20% coinsurance | 40% coinsurance |
| Bariatric Surgery & Travel Expense Benefits<br>Subject to utilization review | | |
| Inpatient Services provided in connection with medically necessary surgery for weight loss, only for morbid obesity | 20% coinsurance | Not covered |
| 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). | Covered (after deductible) | Not covered |
| Organ & Tissue Transplants<br>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<br>*Medical Benefit Lifetime Maximum of $15,000*<br>Coverage includes Artificial Insemination, Invitro Fertilization (including GIFT/ZIFT) | 20% coinsurance | 40% coinsurance |

# Your summary of benefits

Notes:

- 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.
- 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.
- 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-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.
- 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 healthcare 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



Questions: visit us at www.anthem.com/ca