# Your summary of benefits

Anthem BlueCross

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Your Plan: PPO Plus Plan

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 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.*<br>**in the aggregate, but not more than $300 for any one member in the family*<br>***in the aggregate, but not more than $500 for any one member in the family*<br><br>***Penalty for not obtaining preauthorization where required:*** *$200 per occurrence* | $300 per occurrence / $900 family* | $500 person / $1,500 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.*<br>*(PPO & Non-PPO out-of-pocket maximums are exclusive of each other)*<br>**in the aggregate, but not more than $2,500 for any one member in the family*<br>***in the aggregate, but not more than $7,000 for any one member in the family* | $2,500 person / $7,500 family* | $7,000 person / $21,000 family** |
| **Infertility Lifetime Maximum** | $20,000 per member | |
| **Doctor Home and Office Services** | | |
| **Preventive care/screening/immunization**<br>*In-network preventive care is not subject to deductible, if your plan has a deductible.* | No Copay (Deductible waived). | 40% coinsurance |
| **Primary care visit to treat an injury or illness** | $25 copay per visit | 40% coinsurance |
| **Specialist care visit** | $35 copay per visit | 40% coinsurance |
| **Family Planning Services** | | |
| Infertility studies & tests* | 50% coinsurance | Not Covered |

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| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
| --- | --- | --- |
| Infertility treatment* | 50% coinsurance | Not Covered |
| Tubal Ligation | No Copay | 40% coinsurance |
| Vasectomy | $75 copay | 40% coinsurance |
| Counseling & consultation | 20% coinsurance | 40% coinsurance |
| **Subject to $20,000 lifetime maximum for all infertility benefits* | | |
| **Pregnancy, Maternity Care & Abortion** *(continued)* | | |
| Physician office visit<br>Normal delivery, cesarean section, complications of pregnancy & abortion *(newborn routine nursery care covered)* | $25 copay 1st visit, thereafter No copay (deductible waived) | 40% coinsurance |
| Inpatient physician services | 20% coinsurance | 40% coinsurance |
| Hospital & ancillary services | $250/admission then 20% coinsurance | 40% coinsurance |
| **Genetic Testing of Fetus** | 20% coinsurance | 40% coinsurance |
| **Other practitioner visits:** | | |
| Retail health clinic | $25 copay per visit | 40% coinsurance |
| On-line Visit | $25 copay per visit | Not covered |
| Speech Therapy *(limited to 60visits/ calendar year combined with physical therapy, and occupational therapy).* | $25 copay per visit | 40% coinsurance |
| Chiropractor services *(25 visits/ calendar year).* | $25 copay per visit | 40% coinsurance |
| Acupuncture *(25 visits/ calendar year).* | $25 copay per visit | 40% coinsurance |
| **Other services in an office:** | | |
| Allergy testing | $25 copay per visit | 40% coinsurance |

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| --- | --- | --- |
| Allergy treatment *(including serum's)* | No Copay (deductible waived) | 40% coinsurance |
| Chemo/radiation therapy | 20% coinsurance | 40% coinsurance |
| Diabetes Education Program (requires physician supervision) | $25 copay per visit | 40% coinsurance |
| Specialist office visit | $35 copay per visit | 40% coinsurance |
| Hemodialysis | 20% coinsurance | 40% coinsurance |
| Injections & Injected Substances *(administered in doctor's office, including allergy serum & medication)* | No separate Copay | 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 | 20% coinsurance | 40% coinsurance |
| **X-ray:** | | |
| Office *(Not including services in connection with preventive care).* | 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 | 20% coinsurance | 40% coinsurance |
| Freestanding Radiology Center *(Subject to utilization review).* | 20% coinsurance | 40% coinsurance |
| Outpatient Hospital | 20% coinsurance | 40% coinsurance |
| **Emergency and Urgent Care** | | |
| **Emergency room facility services** | $250/admission | $250/admission, |

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|---|---|---|
| | then 20% coinsurance. | after 48 hours 40% coinsurance (unless member cannot be moved). |
| **Emergency room doctor and other services** *(Copay waived if admitted to hospital).* | $100/visit then 20% coinsurance. | $100/visit then 20% coinsurance. |
| **Ambulance (air and ground)** | 20% coinsurance | 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** | $25 copay per visit | 40% coinsurance |
| **Specialist care visit** | 20% coinsurance | 40% coinsurance |
| **Outpatient Mental/Behavioral Health and Substance Abuse** | | |
| **Doctor office visit** | $0 copay for visits 1-5 and then $25 copay for visits 6 and over. | 40% coinsurance |
| **Facility visit:** | | |
| Facility fees | 20% coinsurance | 40% coinsurance |
| **Outpatient Surgery** | | |
| **Facility fees:** | | |
| Hospital | 20% coinsurance | 40% coinsurance |
| Freestanding Surgical Center | 20% coinsurance | 40% coinsurance |
| **Doctor and other services** | 20% coinsurance | 40% coinsurance |

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|---|---|---|
| **Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)** | | |
| **Facility fees (for example, room & board)** *(Preauthorization required for non-emergency admissions).* | $250/admission then 20% coinsurance. | 40% coinsurance |
| **Doctor and other services** | 20% coinsurance | 40% coinsurance |
| **Recovery & Rehabilitation** | | |
| **Home health care** *(Limited to 100 visits/calendar year, one visit by a home health aide equals four hours or less; not covered while member receives hospice care).* | 20% coinsurance | 40% coinsurance |
| **Rehabilitation services (for example, physical/speech/occupational therapy):** *(limited to 60 visits/calendar year combined with physical therapy, occupational therapy, and speech)* | | |
| Office | $25 copay per visit | 40% coinsurance |
| Outpatient hospital | $25 copay per visit | 40% coinsurance |
| Habilitation services | $25 copay per visit | 40% coinsurance |
| **Cardiac rehabilitation** | | |
| Office | 20% coinsurance | 40% coinsurance |
| Outpatient hospital | 20% coinsurance | 40% coinsurance |
| **Skilled nursing care (in a facility)** *(Preauthorization required) (Limited to 240 days/calendar year).* | 20% coinsurance | 40% coinsurance |
| **Hospice** | 20% coinsurance | 40% coinsurance |
| **Durable Medical Equipment** | 20% coinsurance | 40% coinsurance |
| **Prosthetic Devices** *(Scalp hair prosthesis limited to $3,000 lifetime benefit).* | 20% coinsurance | 40% coinsurance |
| **Registered Special Duty Nurse** *(outpatient only; preauthorization required)* | 20% coinsurance | 40% coinsurance |

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|---|---|---|
| **Infusion Therapy** | 20% coinsurance | 40% coinsurance |
| **Hearing Aids** *($2,000 maximum for 1 or 2 hearing aids every 36 months, analog and digital devices are covered)* | 50% coinsurance | Not Covered |
| **Temporomandibular Joint Disorder** *(preauthorization required)* | 20% coinsurance | 40% coinsurance |
| **Transplant Services** *(subject to utilization review)* | | |
| Inpatient services provided in connection with non-investigative organ or tissue transplants | 20% coinsurance | Not covered |
| Physician office visits | $25 copay per visit | Not covered |
| Specialist office visits | $35 copay per visit | Not covered |
| Organ & tissue donor acquisition costs are limited to $10,000 per transplant | No copay (deductible waived) | Not covered |
| Transplant travel expense for an authorized, specified transplant at a CME *(recipient & companion transportation limited to 6 trips/episode & $300/person/trip for round-trip coach airfare, hotel limited to 1 room double occupancy & $100/day for 21 days/trip, other expenses limited to $40/day/person for 21/days/trip; donor transportation limited to $100/day for 7 days, other expenses limited to $40/day for 7 days)* | | |
| **Bariatric Surgery** *(preauthorization required)* Specified Bariatric Surgery will be covered only when performed at a Center of Medical Excellence (CME) | | |
| Inpatient services provided in connection with Bariatric surgery | 20% coinsurance | Not covered |
| Physician office visits | $25 copay per visit | Not covered |
| Specialist office visits | $35 copay per visit | Not covered |
| Bariatric travel expense when member's home is 50 miles or more from the nearest Center of Medical Excellence *(member's transportation to & from CME limited to $130/trip for 3 trips [pre-surgical visit, initial surgery & one follow-up visit]; one companion's* | No copay (deductible waived) | Not covered |

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|---|---|---|
| *transportation to & from CME limited to $130/trip for 2 trips[initial surgery & one follow-up visit]; hotel for member& one companion limited to one room double occupancy & $100/day for 2days/trip or as medically necessary, for pre-surgical & follow-up visit; hotel for one companion limited to one double occupancy & $100/day for duration of member's initial surgery for 4 days)* | | |

- **Members traveling out of the country will be reimbursed at the non-PPO benefit level. Members are responsible for 40% of the billed charges.

**Notes:**

- Annual Out-of-Pocket Maximums includes deductible, copays, coinsurance and prescription drug.
- 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.
- 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.
- 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.
- 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).
- 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.
- Additional visits maybe authorized if medically necessary. Pre-service review must be obtained prior to receiving the additional services.
- All medical services subject to a coinsurance are also subject to the annual medical 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.
- 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.

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