Your summary of benefits

Anthem BlueCross

Anthem Blue Cross Life and Health Insurance Company **PRISM** (Small Group)

Your Plan: Small Group HDHP 20% (Anthem PPO HSA)

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. In-Network Providers and Non-Network Providers deductibles are combined. Satisfying one helps satisfy the other.*	$3,000 single / $6,000 family	$3,000 single / $6,000 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 Providers and Non-Network Providers out-of-pocket limits are combined. Satisfying one helps satisfy the other.*	$5,950 single / $11,900 family	$5,950 single / $11,900 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	Not covered
Doctor Home and Office Services		
Primary care visit to treat an injury or illness	20% coinsurance	50% coinsurance
Specialist care visit	20% coinsurance	50% coinsurance
Prenatal and Post-natal Care	20% coinsurance	50% coinsurance
Other practitioner visits:		
Retail health clinic	20% coinsurance	50% coinsurance
Preferred On-line Visit *Includes Mental/Behavioral Health and Substance Abuse.*	20% coinsurance	50% coinsurance
Chiropractor services *Coverage for In-Network Provider and Non-Network Provider combined is limited to 26 visits per calendar year. Visit limit is combined with Physical Therapy and Occupational Therapy.*	20% coinsurance	50% coinsurance

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Acupuncture *Coverage for In-Network Provider and Non-Network Provider combined is limited to 26 visits per calendar year.*	20% coinsurance	50% coinsurance
Other services in an office:		
Allergy testing	20% coinsurance	50% coinsurance
Chemo/radiation therapy	20% coinsurance	50% coinsurance
Hemodialysis	20% coinsurance	50% coinsurance
Prescription drugs *For the drugs itself dispensed in the office thru infusion/injection.*	20% coinsurance	50% coinsurance
Diagnostic Services		
Lab:		
Office	20% coinsurance	50% coinsurance
Freestanding Lab	20% coinsurance	50% coinsurance
Outpatient Hospital *Coverage for Out-of-Network Provider is limited to $350 maximum per day.*	$25 copay per visit, then 20% coinsurance	50% coinsurance
X-ray:		
Office	20% coinsurance	50% coinsurance
Freestanding Radiology Center	20% coinsurance	50% coinsurance
Outpatient Hospital *Coverage for Out-of-Network Provider is limited to $350 maximum per day.*	$25 copay per visit, then 20% coinsurance	50% coinsurance
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office *Coverage for Out-of-Network Provider is limited to $800 maximum per test.*	20% coinsurance	50% coinsurance
Freestanding Radiology Center *Coverage for Out-of-Network Provider is limited to $800 maximum per test.*	20% coinsurance	50% coinsurance
Outpatient Hospital *Coverage for Out-of-Network Provider is limited to $800 maximum per test.*	$100 copay per visit, then 20% coinsurance	50% coinsurance

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Emergency and Urgent Care		
Emergency room facility services *Copay waived if admitted.*	$100 copay per visit, then 20% coinsurance	Covered as In-Network
Emergency room doctor and other services	20% coinsurance	Covered as In-Network
Ambulance (air and ground)	20% coinsurance	Covered as In-Network
Urgent Care (office setting)	20% coinsurance	50% coinsurance
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit	20% coinsurance	50% coinsurance
Facility visit:		
Facility fees *Coverage for Out-of-Network Provider is limited to $350 maximum per day.*	20% coinsurance	50% coinsurance
Outpatient Surgery		
Facility fees:		
Hospital *Coverage for Out-of-Network Provider is limited to $350 maximum per day.*	20% coinsurance	50% coinsurance
Freestanding Surgical Center *Coverage for Out-of-Network Provider is limited to $350 maximum per day.*	10% coinsurance	50% coinsurance
Doctor and other services	20% coinsurance	50% coinsurance
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)		
Facility fees (for example, room & board) *Coverage for an Out-of-Network Provider is limited to $600 maximum per day for non-emergency admission.*	20% coinsurance	50% coinsurance
Doctor and other services	20% coinsurance	50% coinsurance
Recovery & Rehabilitation		
Home health care *Coverage for In-Network Provider and Non-Network Provider combined is limited to 100 visits per calendar year.*	20% coinsurance	Not covered (unless medically necessary)

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Rehabilitation and Habilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for In-Network Provider and Non-Network Provider combined is limited to 26 visits per calendar year for Physical Therapy and Occupational Therapy. Visit limit is combined with Chiropractor visits.*	20% coinsurance	50% coinsurance
Outpatient hospital *Coverage for In-Network Provider and Non-Network Provider combined is limited to 26 visits per calendar year for Physical Therapy and Occupational Therapy. Coverage for Out-of-Network Provider is limited to $350 maximum per day.*	20% coinsurance	50% coinsurance
Cardiac rehabilitation		
Office	20% coinsurance	50% coinsurance
Outpatient hospital *Coverage for Out-of-Network Provider is limited to $350 maximum per day.*	20% coinsurance	50% coinsurance
Skilled nursing care (in a facility) *Coverage for In-Network Provider and Non-Network Provider combined is limited to 100 days per calendar year.*	20% coinsurance	50% coinsurance
Hospice	20% coinsurance	Not covered (unless medically necessary)
Durable Medical Equipment *Hearing aids benefit available for one hearing aid per ear every three years.*	20% coinsurance	Not covered
Prosthetic Devices	20% coinsurance	Not covered (unless medically necessary)
Home Infusion Therapy	20% coinsurance	Not covered (unless medically necessary)

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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	$0	$0
Pharmacy Out of Pocket Maximum	Combined with medical out of pocket	Combined with medical out of pocket
Prescription Drug Coverage *This plan uses a National Drug list. Drugs not on this list are not covered.*		
Preventive Pharmacy Preventive Immunization *Deductible does not apply.*	$0 copay (retail only)	30% coinsurance (retail only)
Female oral contraceptive *Generic and Single Source brand. Deductible does not apply.*	$0 copay (retail only)	30% coinsurance (retail only)
Generic drugs *Covers up to a 30 day supply (retail pharmacy).* *Covers up to a 90 day supply (home delivery program).* *Member pays the retail pharmacy copay plus 30% for out of network.*	$7 copay per prescription (retail only) and $14 copay per prescription (home delivery only)	30% coinsurance (retail only)
Brand name drugs *Covers up to a 30 day supply (retail pharmacy).* *Covers up to a 90 day supply (home delivery program).* *Member pays the retail pharmacy copay plus 30% for out of network.*	$25 copay per prescription (retail only) and $60 copay per prescription (home delivery only)	30% coinsurance (retail only)
Self-Administered injectable drugs (except insulin) *Covers up to a 30 day supply (retail pharmacy).* *Covers up to a 90 day supply (home delivery program).*	30% of prescription drug maximum allowed amount up to $150 per prescription (retail and home delivery)	30% coinsurance (retail only)
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 home delivery program).*	Applicable copay applies	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 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.
- 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.
- 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 copay and 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 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.

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- 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.
- Transplant travel expense for an authorized, specified transplant at a CME or BDCSC: recipient and companion transportation limited to 6 trips/episode and $250/person/trip for round-trip coach airfare hotel limited to 1 room double occupancy and $100/day for 21 days/trip, other expenses limited to $25/day/person for 21 days/trip; donor transportation limited to 1 trip/episode and $250 for round-trip coach airfare, hotel limited to $100/day for 7 days, other expenses limited to $25/day for 7 days.
- Bariatric Surgery covered only when performed at Blue Distinction Center for Specialty Care for Bariatric Surgery.
- Bariatric travel expense when insured person's home is 50 miles or more from the nearest bariatric BDCSC: insured person's transportation to and from BDCSC limited to $130/person/trip for 3 trips [pre-surgical visit, initial surgery and one follow-up visit]; one companion's transportation to and from BDCSC limited to $130/person/trip for 2 trips [initial surgery and one follow-up visit]; hotel for insured person and one companion limited to one room double occupancy and $100/day for 2 days/trip, or as medically necessary, for pre-surgical and follow-up visit; hotel for one companion limited to one room double occupancy and $100/day for duration of insured person's initial surgery stay for 4 days; other reasonable expenses limited to $25/day/person for 4 days/trip.
- 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
- 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
- This plan includes custom benefits that may supersede some of the information included in the Limitations and Exclusions link provided here. Please see your EOC for full details on your covered benefits.
- For additional information on this plan, please visit sbc.anthem.com to obtain a Summary of Benefit Coverage.