Your Summary of Benefits

Modified Anthem PPO HSA 1500/2700/3000 10/30
(HSA497H)

This Summary of Benefits is a brief overview of your plan's benefits only. The benefits listed are for both in state and out of state members, there may be differences in benefits depending on where you reside. For more detailed information about the benefits in your plan, please refer to your Certificate of Insurance or Evidence of Coverage (EOC), which explains the full range of covered services, as well as any exclusions and limitations for your plan.
Certain Covered Services have maximum visit and/or day limits per year. The number of visits and/or days allowed for these services will begin accumulating on the first visit and/or day, regardless of whether your Deductible has been met. The member is responsible for all costs over the plan maximums. Plan maximums and other important information appear in italics. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Subject to Utilization Review
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.

Explanation of Maximum Allowed Amount
Maximum Allowed Amount is the total reimbursement payable under the plan for covered services received from Participating and Non-Participating Providers. It is the payment towards the services billed by a provider combined with any applicable deductible, copayment or coinsurance.
Participating Providers- The rate the provider has agreed to accept as reimbursement for covered services. Members are not responsible for the difference between the provider's usual charges & the maximum allowed amount.
Non-Participating Providers & Other Health Care Providers-(*includes those not represented in the PPO provider network*)-Reimbursement amount is based on: an Anthem Blue Cross rate or fee schedule, a rate negotiated with the provider, information from a third party vendor, or billed charges. For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement may be based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.
Participating Pharmacies & Mail Service Program-members are not responsible for any amount in excess of the prescription drug maximum allowed amount. Non-Participating Pharmacies-members are responsible for any expense not covered under this plan & any amount in excess of the prescription drug maximum allowed amount.

When using non-participating providers, members are responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay. When using the outpatient prescription drug benefits, members are always responsible for drug expense which is not covered under this plan, as well as any deductible, percentage or dollar copay.

Calendar Year Deductible *(In-network/out-of-network deductibles are exclusive of each other; applicable to medical care & prescription drug benefits; For subscribers with dependents, this plan contains an embedded deductible, meaning that the cost shares of one family member will be applied to the per member deductible; in addition, amounts for all family members apply to the family deductible. No one member will pay more than the per member deductible)*

- Participating Providers, Participating Pharmacy & Other Health Care Providers — $1,500/single; $2,700/ member; $3,000/family
- Non-Participating Providers & Non-Participating Pharmacy — $3,000/single; $3,000/ member; $6,000/family

Annual Out-of-Pocket Maximums *(In-network/out-of-network out-of-pocket maximums are exclusive of each other; includes calendar year deductible & prescription drug maximum allowed amounts. For subscribers with dependents, this plan contains an embedded out of pocket maximum, meaning that the cost shares of one family member will be applied to the per member 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 per member out-of-pocket maximum)*

- Participating Providers, Participating Pharmacy & Other Health Care Providers — $3,000/single; $3,000/ member; $6,000/family
- Non-Participating Providers & Non-Participating Pharmacy — $9,000/single; $9,000/ member; $18,000/family

The following do not apply to out-of-pocket maximums: non-covered expenses. After an annual out-of-pocket maximum is met for medical and prescription drugs during a calendar year, the individual member or family (includes employee & members of the employee's family) will no longer be required to pay a copay or coinsurance for medical and prescription drug covered expenses for the remainder of that year. The member remains responsible for non-covered expenses.

Lifetime Maximum	Unlimited

Covered Services	In-Network	Out-of-Network[††]
Preventive Care Services Preventive Care Services including*, physical exams, preventive screenings *(including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunizations, health education, intervention services, HIV testing)*, and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration. *This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.	No copay (*deductible waived*)	30%
Physician Medical Services		
∘ Office & home visits *(includes retail health clinic & online visit)*	10%	30%
∘ Hospital & skilled nursing facility visits	10%	30%
∘ Surgeon & surgical assistant; anesthesiologist or anesthetist	10%	30%
∘ Drugs administered by a medical provider *(certain drugs are subject to utilization review)*	10%	30%
Diabetes Education Programs *(requires physician supervision)* ∘ Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	10%	30%
∘ **Physical Therapy, Physical Medicine & Occupational Therapy**	10%	30%
∘ **Chiropractic Services** *(limited to 30 visits /calendar year)* [§§]	10%	30%
Speech Therapy	10%	30%
Acupuncture ∘ Services for the treatment of disease, illness or injury *(limited 20 visits/calendar year)*	10%	30%
Diagnostic X-ray & Lab ∘ Other diagnostic x-ray & lab	10%	30%
Advanced Imaging *(subject to utilization review)*	10%	30% *(benefit limited to $800/procedure)*
Urgent Care *(physician services)*	10%	30%
Emergency Care		
∘ Emergency room services & supplies	10%	10%
∘ Physician services	10%	10%

Hospital Medical Services *(subject to utilization review for inpatient and certain outpatient services; waived for emergency admissions)*		
• Semi-private or private room, medically necessary services & supplies	10%	30% *(benefit limited to $1,000/day for non-emergency admission)*
• Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	10%	30% *(benefit limited to $350/admit)*
Skilled Nursing Facility *(subject to utilization review)*		
• Semi-private room, services & supplies *(limited to 100 days/calendar year ; limit does not apply to mental health and substance abuse)*	10%	30%
Related Outpatient Medical Services & Supplies		
• Ground or air ambulance transportation, services & disposable supplies *(air ambulance in a non-medical emergency is subject to pre-service review and benefit limited to $50,000 for non-PPO)*	10%	In an emergency or with an authorized referral: 10%; Non-emergency: 30%
• Blood transfusions, blood processing & the cost of unreplaced blood & blood products[f]	10%	10%
• Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)* [f]	10%	10%
Ambulatory Surgical Centers *(certain surgeries are subject to utilization review)*		
• Outpatient surgery, services & supplies	10%	30% *(benefit limited to $350/admit)*
Pregnancy & Maternity Care		
• Physician office visits	10%	30%
• Prescription drug for abortion (*mifepristone*)	10%	30%
Normal delivery, cesarean section, complications of pregnancy & abortion. Refer to the Physician & Hospital Medical Services benefits for both inpatient and outpatient hospital coverage.		
Mental or Nervous Disorders and Substance Abuse		
• Inpatient facility care *(subject to utilization review; waived for emergency admissions)*	10%	30% *(benefit limited to $1,000/per day for non-emergency admission)*
• Inpatient physician visits	10%	30%
• Outpatient facility care	10% *(after deductible is met)*	30% *(after deductible is met)*
• Physician office visits *(Behavioral Health treatment for Autism or Pervasive Development disorders require pre-service review)*	10% *(after deductible is met)*	30% *(after deductible is met)*
Durable Medical Equipment *(may be subject to utilization review)*		
• Rental or purchase of DME *(breast pump and supplies are covered under preventive care at no charge for in-network)*	50%	50%

Home Health Care *(subject to utilization review)* • Services & supplies from a home health agency *(limited to 100 visits/calendar year, one visit by a home health aide equals four hours or less)*	10%	30%
Home Infusion Therapy *(subject to utilization review)* • Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	10%	30% (*benefit limited to $600/day*)
Hemodialysis • Outpatient hemodialysis services & supplies	10%	30% *(benefit limited to $350/visit for free standing hemodialysis center)*
Hospice Care • Inpatient or outpatient services; family bereavement services	10%	30%
Bariatric Surgery *(subject to utilization review; covered only when performed at a Blue Distinction Centers for Speciality Care [BDCSC])* • Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity • Travel expenses for an authorized, specified surgery *(recipient & companion transportation limited to $3,000 per surgery)*	10% No copay	Not covered†† Not covered††
Organ & Tissue Transplants *(subject to utilization review; specified transplants covered only when performed at Centers of Medical Excellence [CME] and Blue Distinction Centers for Specialty Care [BDCSC] for California; Blue Distinction Centers for Specialty Care [BDCSC] for out of California)* • Inpatient services provided in connection with non-investigative organ or tissue transplants • Transplant travel expense for an authorized, specified transplant *(recipient & companion transportation limited to $10,000 per transplant)* • Unrelated donor search, limited to $30,000 per transplant	10% No copay	Not covered†† Not covered††
Prosthetic Devices • Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; wigs for alopecia resulting from chemotherapy or radiation therapy; & therapeutic shoes & inserts for members with diabetes	10%	30%

Outpatient Prescription Drug Benefits (*This plan uses an Essential formulary List. Drugs not on the list are not covered. Until the calendar year deductible is satisfied, the member pays the prescription drug covered expense, and not the copays listed below*.) Your copay is determined by whether it is tier 1, tier 2, tier 3 or tier 4 drug. To determine tier status, the tiered drug formulary list is furnished to your provider and is also available online at www.anthem.com/ca, click on Customer Care, Download Forms and then choose Anthem Blue Cross Drug List (tiered). You may also contact our pharmacy customer service at 800-700-2541.		
Retail Participating Pharmacy • Preventive Immunizations administered by a retail pharmacy • Female oral contraceptives generic and single source brand • Tier 1 drugs *(includes diabetic supplies)* • Tier 2 drugs • Tier 3 drugs *(includes compound drugs)* • Tier 4 drugs ‡	No copay *(deductible waived)* No copay *(deductible waived)* $15 $30 $50 30% of prescription drug maximum allowed amount *(maximum $150 copay per fill)*	All Tiers: 30% of the prescription drug maximum allowed amount & costs in excess of the prescription drug maximum allowed amount up to $250 per prescription *(compound drugs & specialty pharmacy drugs not covered)*

Home Delivery Program • Female oral contraceptives generic and single source brand • Tier 1 drugs *(includes diabetic supplies)* • Tier 2 drugs • Tier 3 drugs • Tier 4 drugs ‡	No copay (*deductible waived)* $15 $60 $100 30% of prescription drug maximum allowed amount *(maximum $300 copay per fill for a 90-day supply)*	
Rx Choice Tiered Network The Rx Choice Tiered Network includes pharmacies that give you more choices and flexibility when you fill prescriptions. It's also convenient — you'll find many popular grocery chains, stores and independent drugstores in the network. You can keep using the pharmacy you've been using, but you'll **pay more** for your prescription drugs unless you transfer your prescription(s) as soon as possible to another participating pharmacy. You can choose a pharmacy from two levels. **Level 1** has up to 25,000 pharmacies and offers you a lower copay or coinsurance (the part you pay for your drugs) than pharmacies in **Level 2**. Filling prescriptions at a **Level 1** pharmacy will help you lower your out-of-pocket costs.	**Level 1:** Applicable retail copays apply **Level 2**: Applicable retail copays apply plus an additional $10	
Specialty Pharmacy Program Certain specialty pharmacy drugs may only be obtained through the specialty pharmacy program and are limited to a 30 day supply. Please contact customer service number on the back of your ID card to see if your drug is on the specialty pharmacy program or you can get a list of drugs required to be dispensed by our specialty pharmacy program at anthem.com/ca. From our home page: Click on **Customer Care;** Then select "**I need to: Choose: Download Forms**"; In the pharmacy library section, click on "**Specialty Drug List**."	Applicable copay applies	

Supply Limits[†] • Retail Pharmacy (*participating and non-participating*) • Home Delivery • Specialty Pharmacy	30-day supply; 60-day supply for federally classified Schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies); 90-day supply for eligible prescriptions obtained through a retail pharmacy, but will require a triple copay 90-day supply 30-day supply	

The Outpatient Prescription Drug Benefit covers the following:

- All eligible immunizations administered by a participating retail pharmacy.
- Outpatient prescription drugs and medications which the law restricts to sale by prescription. Formulas prescribed by a physician for the treatment of phenylketonuria.
- Insulin.
- Syringes when dispensed for use with insulin and other self-injectable drugs or medications.
- All compound prescription drugs that contain at least one covered prescription ingredient
- All FDA-approved contraceptives for women, including oral contraceptives; contraceptive diaphragms and over-the-counter contraceptives prescribed by a doctor.
- Injectable drugs which are self-administered by the subcutaneous route (under the skin) by the patient or member.
- Drugs that have Food and Drug Administration (FDA) labeling for self-administration
- Diabetic supplies (i.e., test strips and lancets)
- Prescription drugs for treatment of impotence and/or sexual dysfunction are limited to organic (non-psychological) causes.
- Inhaler spacers and peak flow meters for the treatment of pediatric asthma.
- Smoking cessation products requiring a physician's prescription.
- Certain over-the-counter drugs approved by the Pharmacy and Therapeutics Committee to be included in the prescription drug formulary.

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.

In addition to the benefits described above, 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 proposed benefit summary is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care.

† Supply limits for certain drugs may be different. Please refer to the Certificate of Insurance or EOC for complete information.

‡ Classified specialty drugs must be obtained through our Specialty Pharmacy Program and are subject to the terms of the program.

f These providers may not be represented in the PPO network in the state where the member receives services.

†† Exception: If service is performed at a Centers of Medical Excellence [CME] for California or Blue Distinction Centers for Speciality Care [BDCSC] for out of California, the services will be covered same as the PPO (in-network) benefit.

‡‡ Member pays copay plus all charges in excess of the maximum allowed amount.

§§ Additional visits as authorized if medically necessary; pre-service review must be obtained prior to receiving the services.

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