Your summary of benefits

Anthem BlueCross

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Your Plan: EPO 1000/20/20 (Essential Formulary $5/$20/$40/$60/30%)

Your Network: EPO

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.*	$1,000 single / $3,000 family	$0
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.*	$5,500 single / $11,000 family	$0
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 *Deductible does not apply.*	$20 copay per visit	Not covered
Specialist care visit *Deductible does not apply.*	$20 copay per visit	Not covered
Prenatal and Post-natal Care *Deductible does not apply.*	$20 copay per visit	Not covered
Other practitioner visits: Retail health clinic *Deductible does not apply.*	$20 copay per visit	Not covered
On-line Visit *Deductible does not apply.*	$10 copay per visit	Not covered

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Chiropractor services *Coverage for In-Network Provider is limited to 30 visit limit per benefit period. Deductible does not apply.*	$20 copay per visit	Not covered
Acupuncture *Coverage for In-Network Provider is limited to 20 visit limit per benefit period. Deductible does not apply.*	$20 copay per visit	Not covered
Other services in an office:		
Allergy testing	20% coinsurance	Not covered
Chemo/radiation therapy	20% coinsurance	Not covered
Hemodialysis	20% coinsurance	Not covered
Prescription drugs *For the drugs itself dispensed in the office thru infusion/injection*	20% coinsurance	Not covered
Diagnostic Services		
Lab:		
Office	20% coinsurance	Not covered
Freestanding Lab	20% coinsurance	Not covered
Outpatient Hospital	20% coinsurance	Not covered
X-ray:		
Office	20% coinsurance	Not covered
Freestanding Radiology Center	20% coinsurance	Not covered
Outpatient Hospital	20% coinsurance	Not covered
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office	20% coinsurance	Not covered
Freestanding Radiology Center	20% coinsurance	Not covered
Outpatient Hospital	20% coinsurance	Not covered
Emergency and Urgent Care		
Emergency room facility services *This is for the hospital/facility charge only. The ER physician charge may be*	$150 copay per admission and then	Covered as In-Network

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separate. Copay waived if admitted.	20% coinsurance	
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) *Deductible does not apply.*	$20 copay per visit	Not covered
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit	$20 copay per visit; deductible does not apply	Not covered
Facility visit:		
Facility fees	20% coinsurance after deductible is met.	Not covered
Outpatient Surgery		
Facility fees:		
Hospital	20% coinsurance	Not covered
Freestanding Surgical Center	20% coinsurance	Not covered
Doctor and other services	20% coinsurance	Not covered
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)		
Facility fees (for example, room & board)	20% coinsurance	Not covered
Doctor and other services	20% coinsurance	Not covered
Recovery & Rehabilitation		
Home health care *Coverage for In-Network Provider is limited to 100 visit limit per benefit period.*	20% coinsurance	Not covered

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Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Costs may vary by site of service.*	20% coinsurance	Not covered
Outpatient hospital	20% coinsurance	Not covered
Habilitation services	20% coinsurance	Not covered
Cardiac rehabilitation		
Office	20% coinsurance	Not covered
Outpatient hospital	20% coinsurance	Not covered
Skilled nursing care (in a facility) *Coverage for In-Network Provider is limited to 100 day limit per benefit period.*	20% coinsurance	Not covered
Hospice	No charge	Not covered
Durable Medical Equipment	50% coinsurance	Not covered
Prosthetic Devices	20% coinsurance	Not covered

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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	Combined with medical out of pocket	Combined with medical out of pocket
Prescription Drug Coverage *This plan uses an Essential formulary List. Drugs not on the list are not covered.*		
Tier1 - Typically Generic *Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program) This plan uses an Essential Formulary drug list. You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Member pays the retail pharmacy copay plus 50% for out of network.*	Tier1a - Typically Lower Cost Generic $5 copay per prescription (retail only) and $12.50 copay per prescription (home delivery only) Tier1b - Typically Generic $20 copay per prescription (retail only) and $50 copay per prescription (home delivery only).	Tier 1a 50% (retail only) Tier 1b 50% (retail only).
Tier2 - Typically Preferred / Brand *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 50% for out of network.*	Tier 2 - Typically Preferred Brand & non-preferred generic drugs $40 copay per prescription (retail only) and $120 copay per prescription (home delivery only).	Tier 2 - 50% coinsurance (retail only).
Tier3 - Typically Non-Preferred / Specialty Drugs *Certain drugs require preauthorization approval to obtain coverage. Covers up to*	Tier 3 - Typically Non-Preferred	Tier 3 -50% coinsurance (retail

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a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program) Member pays the retail pharmacy copay plus 50% for out of network.	Brand and generic drugs $60 copay per prescription (retail only) and $180 copay per prescription (home delivery only.	only).
Tier4 - Typically 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) Member pays the retail pharmacy copay plus 50% for out of network.*	Tier 4 - Typically Specialty (brand and generic) 30% coinsurance up to $250 per prescription (retail and home delivery).	Tier 4 - 50% coinsurance (retail only).

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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 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.
- 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.
- 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 plans with an office visit copay, the copay applies to the actual office visit and additional cost shares may apply for any other service performed in the office (i.e., X-ray, lab, surgery), after any applicable deductible.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- 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.
- Additional visits maybe authorized if medically necessary. Pre-service review must be obtained prior to receiving the additional services.
- Transplants covered only when performed at Centers of Medical Excellence or Blue Distinction Centers.
- Bariatric Surgery covered only when performed at Blue Distinction Center for Specialty Care for Bariatric Surgery.
- Skilled Nursing Facility day limit does not apply to mental health and substance abuse.
- Respite Care limited to 5 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

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- When using non-network pharmacy; members are responsible for in-network pharmacy copay plus 50% of the remaining prescription drug maximum allowed amount & costs in excess of the prescription drug maximum allowed amount. Members will pay upfront and submit a claim form.
- 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_EPO
- For additional information on this plan, please visit sbc.anthem.com to obtain a Summary of Benefit Coverage.

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