Your summary of benefits

Anthem BlueCross

Anthem Blue Cross ACWA JPIA – C00361

Your Plan: 2018 Classic PPO Plan (1VYV) – Medical benefits only plan for retirees with Medicare A&B

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	Your cost if you use an In-Network Provider	Your cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works. Prescription drugs are not included in the deductible. In-Network Providers and Non-Network Providers deductibles are combined. Satisfying one helps satisfy the other.*	$200 single / $600 family	$200 single / $600 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.*	$2,000 single / $4,000 family	$2,000 per person
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	20% coinsurance
Primary care visit to treat an injury or illness *Deductible does not apply to In-Network providers.*	$15 copay per visit	20% coinsurance
Specialist care visit *Deductible does not apply to In-Network providers.*	$15 copay per visit	20% coinsurance
Prenatal and Post-natal Care	20% coinsurance	20% coinsurance
Other practitioner visits:		
Retail health clinic *Deductible does not apply to In-Network providers.*	$15 copay per visit	20% coinsurance
On-line Visit *Deductible does not apply to In-Network providers.*	$0 copay per visit	Not covered

Your summary of benefits

Covered Medical Benefits	Your cost if you use an In-Network Provider	Your cost if you use a Non-Network Provider
Chiropractor services *Coverage for In-Network Provider and Non-Network Provider combined is limited to 30 visits per calendar year. Limit is combined with Physical Therapy, Physical Medicine, and Occupational Therapy.*	20% coinsurance	20% coinsurance
Acupuncture *Coverage for In-Network Provider and Non-Network Provider combined is limited to 12 visits per calendar year.*	20% coinsurance	40% coinsurance
Other services in an office:		
Allergy testing	20% coinsurance	20% coinsurance
Chemo/radiation therapy	20% coinsurance	20% coinsurance
Prescription drugs *For the drugs itself dispensed in the office thru infusion/injection*	20% coinsurance	20% coinsurance
Diagnostic Services		
Lab:		
Office	20% coinsurance	20% coinsurance
Freestanding Lab *Coverage for Out-of-Network Provider is limited to $350 maximum per visit.*	20% coinsurance	20% coinsurance
Outpatient Hospital *Coverage for Out-of-Network Provider is limited to $350 maximum per visit.*	20% coinsurance	20% coinsurance
X-ray:		
Office	20% coinsurance	20% coinsurance
Freestanding Radiology Center *Coverage for Out-of-Network Provider is limited to $350 maximum per visit.*	20% coinsurance	20% coinsurance
Outpatient Hospital *Coverage for Out-of-Network Provider is limited to $350 maximum per visit.*	20% coinsurance	20% coinsurance

Your summary of benefits

Covered Medical Benefits	Your cost if you use an In-Network Provider	Your cost if you use a Non-Network Provider
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office	20% coinsurance	20% coinsurance
Freestanding Radiology Center *Coverage for Out-of-Network Provider is limited to $800 maximum per test.*	20% coinsurance	20% coinsurance
Outpatient Hospital *Coverage for Out-of-Network Provider is limited to $800 maximum per test.*	20% coinsurance	20% coinsurance
Emergency and Urgent Care		
Emergency room facility services *Copay waived if admitted. This is for the hospital/facility charge only. The ER physician charge may be separate. Copay waived if admitted.*	$50 copay per visit and 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) *Deductible does not apply to In-Network providers.*	$15 copay per visit	20% coinsurance
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit *Deductible does not apply to In-Network providers.*	$15 copay per visit	20% coinsurance
Facility visit:		
Facility fees	20% coinsurance	20% coinsurance
Outpatient Surgery		
Facility fees:		
Hospital *Coverage for Out-of-Network Provider is limited to $350 maximum per visit.*	10% coinsurance	20% coinsurance
Freestanding Surgical Center *Coverage for Out-of-Network Provider is limited to $350 maximum per visit.*	10% coinsurance	20% coinsurance
Doctor and other services	20% coinsurance	20% coinsurance

Your summary of benefits

Covered Medical Benefits	Your cost if you use an In-Network Provider	Your cost if you use a Non-Network Provider
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)		
Facility fees (for example, room & board) *Additional 10% coinsurance applies if you do not receive preauthorization. Coverage is limited to $600 maximum per day for Out-of-Network Provider. Applies to non-emergency admission.*	10% coinsurance	20% coinsurance
Doctor and other services	20% coinsurance	20% coinsurance
Recovery & Rehabilitation		
Home health care *Coverage for In-Network Provider and Non-Network Provider combined is limited to 100 visit limit per benefit period.*	10% coinsurance	20% coinsurance
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for In-Network Provider and Non-Network Provider combined for Physical Therapy, Physical Medicine, Occupational Therapy, and Chiropractor Services is limited to 30 visits per calendar year (additional visits may be authorized).*	20% coinsurance	20% coinsurance
Outpatient hospital *Coverage for In-Network Provider and Non-Network Provider combined for Physical Therapy, Physical Medicine, Occupational Therapy, and Chiropractor Services is limited to 30 visits per calendar year (additional visits may be authorized).*	20% coinsurance	20% coinsurance
Habilitation services *Habilitation visits count towards your Rehabilitation limit.* Office & Outpatient hospital	20% coinsurance	20% coinsurance
Cardiac rehabilitation		
Office	20% coinsurance	20% coinsurance
Outpatient hospital	20% coinsurance	20% coinsurance
Skilled nursing care (in a facility) *Coverage for In-Network Provider and Non-Network Provider combined is limited to 100 visit limit per benefit period.*	10% coinsurance	20% coinsurance

Your summary of benefits

Covered Medical Benefits	Your cost if you use an In-Network Provider	Your cost if you use a Non-Network Provider
Hospice	10% coinsurance	10% coinsurance
Durable Medical Equipment *Hearing aids benefit limited to 1 per ear every 3 years.*	20% coinsurance	20% coinsurance
Prosthetic Devices	20% coinsurance	20% coinsurance
Hemodialysis Outpatient hospital *Coverage for Out-of-Network Provider is limited to $350 maximum per visit.*	20% coinsurance	20% coinsurance
Freestanding hemodialysis center *Coverage for Out-of-Network Provider is limited to $350 maximum per visit.*	20% coinsurance	20% coinsurance

Your summary of benefits

Notes:

- This Summary of Benefits has been updated to comply with federal 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.
- 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, and coinsurance.
- In network and out of network out of pocket maximum are exclusive of each other.
- 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.
- 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.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- 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.
- 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.
- 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 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

- 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_PPO