Blue Cross PPO

- High (40425-A)

Employee pays $190 monthly.

- Medium (40425-B),

Employee pays $137 monthly.

- Low(40425-C),

Employee pays 0 (Free) monthly.

(40425-A) * High You Pay $ 140 per month

SISC 90 C $10 Anthem Classic PPO

PPO Benefits

In addition to dollar and percentage copays, members are responsible for deductibles, as described below. Please review the deductible information to know if a deductible applies to a specific covered service. 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. Members are also 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.

Explanation of Covered Expense

Plan payments are based on covered expense, which is the lesser of the charges billed by the provider or the following:

PPO Providers—PPO negotiated rates. Members are not responsible for the difference between the provider's usual charges & the negotiated amount.

Non-PPO Providers—For non-emergency services, the scheduled amount. For emergency services, same as other health care providers

Other Health Care Providers *(includes those not represented in the PPO provider network)*—The customary & reasonable charge for professional services or the reasonable charge for institutional services.

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.

Calendar year deductible for all providers	$200/member; $500//family
Co-pay for emergency room services	$100/visit *(waived if admitted directly from ER)*
Annual Out-of-Pocket Maximums	
All Providers	$300/member/year; $900/family/year

The following do not apply to out-of-pocket maximums: deductibles listed above; non-covered expense, and co-pays. After a member reaches the out-of-pocket maximum, the member remains responsible for deductibles listed above; for non-PPO providers & other health care providers, costs in excess of the covered expense; amounts related to a transplant unrelated donor search, and office visit co-pays.

Lifetime Maximum	None	
Covered Services	**PPO: Per Member Copay**	**Non-PPO: Per Member Copay[1]**
Hospital Medical Services *(subject to utilization review for inpatient services; waived for emergency admissions)*		
➢ Semi-private room, meals & special diets, & ancillary services	10%	0% *(benefit limited to $600/day)*
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	10%	50%
Ambulatory Surgical Centers		
➢ Outpatient surgery, services & supplies	10%	0% *(benefit limited to $350/day)*
Hemodialysis		
➢ Outpatient hemodialysis services & supplies	10%	0% *(benefit limited to $350/day)*
Skilled Nursing Facility *(subject to utilization review)*		
➢ Semi-private room, services & supplies *(limited to 100 days/calendar year)*	10%	0% *(benefit limited to $600/day)*
Hospice Care		
➢ Inpatient or outpatient services; family bereavement services	10%[2]	

[1]The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount. Member is responsible for all charges exceeding the scheduled amount.

[2] These providers are not represented in the Anthem Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
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; not covered while member receives hospice care)*	10%	0%
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%	0% *(benefit limited to $600/day)*
Physician Medical Services		
➢ Office & home visits	$10/visit[2] *(deductible waived)*	0%
➢ Hospital & skilled nursing facility visits	10%	0%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	10%	0%
Diagnostic X-ray & Lab		
➢ MRI, CT scan, PET scan & nuclear cardiac scan *(subject to utilization review)*	10%	0%
➢ Other diagnostic x-ray & lab	10%	0%
Well Baby & Well-Child Care for Dependent Children		
➢ Routine physical examinations *(birth through age six)*	No co-pay *(deductible waived)*	0% *(benefit limited to $20/exam)*
➢ Immunizations *(birth through age six)*	0% *(deductible waived)*	0% *(benefit limited to $12/immunization)*
Physical Exams for Members Ages Seven & Older		
➢ Routine physical exams, immunizations, diagnostic X-ray & lab for routine physical exam	0% No co-pay *(deductible waived)*	Not covered
Adult Preventive Services *(including mammograms, Pap smears, prostate cancer screenings & colorectal cancer screenings)*	0% *(deductible waived)*	0%
Physical Therapy, Physical Medicine & Occupational Therapy, including Chiropractic Services *(subject to medical necessity review administered by American Specialty Health - ASH)*	10%	0%
Speech Therapy		
➢ Outpatient speech therapy following injury or organic disease	10%	0%
Acupuncture		
➢ Services for the treatment of disease, illness or injury *(limited 12 visits/calendar year)*	10%[3] *(benefit limited to $50/visit)*	0%[3] *(benefit limited to $25/visit)*
Temporomandibular Joint Disorders		
➢ Splint therapy & surgical treatment	10%	0%
Pregnancy & Maternity Care		
➢ Physician office visits	$10/visit[2] *(deductible waived)*	0%
➢ Prescription drug for elective abortion *(mifepristone)*	10%	0%
Normal delivery, cesarean section, complications of pregnancy & abortion *(newborn routine nursery care covered when natural mother is subscriber or spouse/domestic partner)*		
➢ Inpatient physician services	10%	0%
➢ Hospital & ancillary services	10%	0% (benefit limited to $600/day)

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount. Member is responsible for all charges exceeding the scheduled amount.

[2] The dollar copay applies only to the visit itself. An additional 10% copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

[3] Acupuncture services can be performed by a certified acupuncturist (C.A.), a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a podiatrist (D.P.M.), or a dentist (D.D.S.).

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Organ & Tissue Transplants *(subject to utilization review; specified organ transplants covered only when performed at Centers of Medical Excellence [CME])*		
➢ Inpatient services provided in connection with non-investigative organ or tissue transplants	10%	Not covered
➢ Transplant travel expense for an authorized, specified transplant at a *CME* *(recipient & companion transportation limited to $10,000 per transplant)*	No copay *(deductible waived)*	
➢ Unrelated donor search, limited to $30,000 per transplant		
Bariatric Surgery *(subject to utilization review; medically necessary surgery for weight loss, only for morbid obesity covered only when performed at Centers of Medical Excellence [CME])*		
➢ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity	10%	Not covered
➢ Bariatric travel expense when member's home is 50 miles or more from the nearest Bariatric *CME* *(transportation to & from CME, hotel accommodations and incidentals for member and companion limited to a maximum reimbursement of $500 total per trip. Hotel accommodations for member and companion double occupancy limited to $174 per day or billed amount; which ever is less. Mileage is reimbursed based on Internal Revenue mileage rates at the time of travel. Number of trips is unlimited based on medical necessity. Lodging expenses for band adjustments and expenses for tobacco, alcohol and meals are excluded.)*	No copay *(deductible waived)*	
Diabetes Education Programs *(requires physician supervision)*		
➢ Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	$10/visit *(deductible waived)*	0%
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; & therapeutic shoes & inserts for members with diabetes	10%	0%
Durable Medical Equipment		
➢ Rental or purchase of DME including hearing aids, dialysis equipment & supplies	10%	0%
Hearing Aid		
➢ Supplies and equipment *(limited to $700 per 24 months)*	10%	0%
Related Outpatient Medical Services & Supplies		
➢ Ground or air ambulance transportation, services & disposable supplies	10%[2]	
➢ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	10%[2]	
➢ Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)*	10%[2]	

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount. Member is responsible for all charges exceeding the scheduled amount.

[2] These providers are not represented in the Anthem Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Specialty Pharmacy Drugs *(utilization review may be required)*		
➢ Specialty pharmacy drugs filled through the specialty pharmacy program *(limited to 30-day supply; not covered if benefits are provided through prescription drug benefits, if applicable)*	10%	Not covered[2]
If member does not get specialty pharmacy drugs from the specialty pharmacy program, member will not receive any specialty pharmacy drug benefits under this plan, unless the member qualifies for an exception as specified in the EOC.		
Emergency Care		
➢ Emergency room services & supplies *($100 co-pay waived if admitted)*	10%	0%
➢ Inpatient hospital services & supplies	10%	10% first 48 hours; 0% limited to $600/day after 48 hours (unless member can not be moved safely)
➢ Physician services	10%	10%[3]
Mental or Nervous Disorders and Substance Abuse		
Inpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	10%	0% *(benefit limited to $600/day)*
➢ Inpatient physician visits	10%	0%
Outpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	10%	50%
➢ Outpatient physician visits *(pre-service review required after the 12th visit)*	$10 *(deductible waived)*	0%

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount. Member is responsible for all charges exceeding the scheduled amount.

[2] 10% copay if member or non-PPO physician obtains drug from Specialty Pharmacy Program; otherwise, not covered.

[3] The allowable rate for emergency within 48 hours is based on a reasonable charge, not the scheduled amount.

This Summary of Benefits is a brief review of benefits. Once enrolled, members will receive a Combined Evidence of Coverage and Disclosure Form, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.

(40425 B) * medium   You pay $137 per month

SISC 90 E $20 Anthem Classic PPO

PPO Benefits

In addition to dollar and percentage copays, members are responsible for deductibles, as described below. Please review the deductible information to know if a deductible applies to a specific covered service. 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. Members are also 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.

Explanation of Covered Expense

Plan payments are based on covered expense, which is the lesser of the charges billed by the provider or the following:

PPO Providers—PPO negotiated rates. Members are not responsible for the difference between the provider's usual charges & the negotiated amount.

Non-PPO Providers—For non-emergency services, the scheduled amount. For emergency services, same as other health care providers

Other Health Care Providers *(includes those not represented in the PPO provider network)*—The customary & reasonable charge for professional services or the reasonable charge for institutional services.

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.

Calendar year deductible for all providers	$300/member; $600//family
Co-pay for emergency room services	$100/visit *(waived if admitted directly from ER)*

Annual Out-of-Pocket Maximums

All Providers	$600/member/year; $1800/family/year

The following do not apply to out-of-pocket maximums: deductibles listed above; non-covered expense, and co-pays. After a member reaches the out-of-pocket maximum, the member remains responsible for deductibles listed above; for non-PPO providers & other health care providers, costs in excess of the covered expense; amounts related to a transplant unrelated donor search, and office visit co-pays.

Lifetime Maximum	None

Covered Services	**PPO: Per Member Copay**	**Non-PPO: Per Member Copay[1]**
Hospital Medical Services *(subject to utilization review for inpatient services; waived for emergency admissions)*		
➢ Semi-private room, meals & special diets, & ancillary services	10%	0% *(benefit limited to $600/day)*
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	10%	50%
Ambulatory Surgical Centers		
➢ Outpatient surgery, services & supplies	10%	0% *(benefit limited to $350/day)*
Hemodialysis		
➢ Outpatient hemodialysis services & supplies	10%	0% *(benefit limited to $350/day)*
Skilled Nursing Facility *(subject to utilization review)*		
➢ Semi-private room, services & supplies *(limited to 100 days/calendar year)*	10%	0% *(benefit limited to $600/day)*
Hospice Care		
➢ Inpatient or outpatient services; family bereavement services	10%[2]	

[1]The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount. Member is responsible for all charges exceeding the scheduled amount.

[2] These providers are not represented in the Anthem Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
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; not covered while member receives hospice care)*	10%	0%
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%	0% *(benefit limited to $600/day)*
Physician Medical Services		
➢ Office & home visits	$20/visit[2] *(deductible waived)*	0%
➢ Hospital & skilled nursing facility visits	10%	0%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	10%	0%
Diagnostic X-ray & Lab		
➢ MRI, CT scan, PET scan & nuclear cardiac scan *(subject to utilization review)*	10%	0%
➢ Other diagnostic x-ray & lab	10%	0%
Well Baby & Well-Child Care for Dependent Children		
➢ Routine physical examinations *(birth through age six)*	No co-pay *(deductible waived)*	0% *(benefit limited to $20/exam)*
➢ Immunizations *(birth through age six)*	0% *(deductible waived)*	0% *(benefit limited to $12/immunization)*
Physical Exams for Members Ages Seven & Older		
➢ Routine physical exams, immunizations, diagnostic X-ray & lab for routine physical exam	0% No co-pay *(deductible waived)*	Not covered
Adult Preventive Services *(including mammograms, Pap smears, prostate cancer screenings & colorectal cancer screenings)*	0% *(deductible waived)*	0%
Physical Therapy, Physical Medicine & Occupational Therapy, including Chiropractic Services *(subject to medical necessity review administered by American Specialty Health - ASH)*	10%	0%
Speech Therapy		
➢ Outpatient speech therapy following injury or organic disease	10%	0%
Acupuncture		
➢ Services for the treatment of disease, illness or injury *(limited 12 visits/calendar year)*	10%[3] *(benefit limited to $50/visit)*	0%[3] *(benefit limited to $25/visit)*
Temporomandibular Joint Disorders		
➢ Splint therapy & surgical treatment	10%	0%
Pregnancy & Maternity Care		
➢ Physician office visits	$20/visit[2] *(deductible waived)*	0%
➢ Prescription drug for elective abortion *(mifepristone)*	10%	0%
Normal delivery, cesarean section, complications of pregnancy & abortion *(newborn routine nursery care covered when natural mother is subscriber or spouse/domestic partner)*		
➢ Inpatient physician services	10%	0%
➢ Hospital & ancillary services	10%	0% (benefit limited to $600/day)

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount. Member is responsible for all charges exceeding the scheduled amount.

[2] The dollar copay applies only to the visit itself. An additional 10% copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

[3] Acupuncture services can be performed by a certified acupuncturist (C.A.), a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a podiatrist (D.P.M.), or a dentist (D.D.S.).

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Organ & Tissue Transplants *(subject to utilization review; specified organ transplants covered only when performed at Centers of Medical Excellence [CME])*		
➢ Inpatient services provided in connection with non-investigative organ or tissue transplants	10%	Not covered
➢ Transplant travel expense for an authorized, specified transplant at a *CME* *(recipient & companion transportation limited to $10,000 per transplant)*	No copay *(deductible waived)*	
➢ Unrelated donor search, limited to $30,000 per transplant		
Bariatric Surgery *(subject to utilization review; medically necessary surgery for weight loss, only for morbid obesity covered only when performed at Centers of Medical Excellence [CME])*		
➢ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity	10%	Not covered
➢ Bariatric travel expense when member's home is 50 miles or more from the nearest Bariatric *CME* *(transportation to & from CME, hotel accommodations and incidentals for member and companion limited to a maximum reimbursement of $500 total per trip. Hotel accommodations for member and companion double occupancy limited to $174 per day or billed amount; which ever is less. Mileage is reimbursed based on Internal Revenue mileage rates at the time of travel. Number of trips is unlimited based on medical necessity. Lodging expenses for band adjustments and expenses for tobacco, alcohol and meals are excluded.)*	No copay *(deductible waived)*	
Diabetes Education Programs *(requires physician supervision)*		
➢ Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	$20/visit *(deductible waived)*	0%
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; & therapeutic shoes & inserts for members with diabetes	10%	0%
Durable Medical Equipment		
➢ Rental or purchase of DME including hearing aids, dialysis equipment & supplies	10%	0%
Hearing Aid		
➢ Supplies and equipment *(limited to $700 per 24 months)*	10%	0%
Related Outpatient Medical Services & Supplies		
➢ Ground or air ambulance transportation, services & disposable supplies	10%[2]	
➢ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	10%[2]	
➢ Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)*	10%[2]	

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount. Member is responsible for all charges exceeding the scheduled amount.

[2] These providers are not represented in the Anthem Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Specialty Pharmacy Drugs *(utilization review may be required)*		
➢ Specialty pharmacy drugs filled through the specialty pharmacy program *(limited to 30-day supply; not covered if benefits are provided through prescription drug benefits, if applicable)*	10%	Not covered[2]
If member does not get specialty pharmacy drugs from the specialty pharmacy program, member will not receive any specialty pharmacy drug benefits under this plan, unless the member qualifies for an exception as specified in the EOC.		
Emergency Care		
➢ Emergency room services & supplies *($100 co-pay waived if admitted)*	10%	0%
➢ Inpatient hospital services & supplies	10%	10% first 48 hours; 0% limited to $600/day after 48 hours (unless member can not be moved safely)
➢ Physician services	10%	10%[3]
Mental or Nervous Disorders and Substance Abuse		
Inpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	10%	0% *(benefit limited to $600/day)*
➢ Inpatient physician visits	10%	0%
Outpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	10%	50%
➢ Outpatient physician visits *(pre-service review required after the 12th visit)*	$20 *(deductible waived)*	0%

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount. Member is responsible for all charges exceeding the scheduled amount.

[2] 10% copay if member or non-PPO physician obtains drug from Specialty Pharmacy Program; otherwise, not covered.

[3] The allowable rate for emergency within 48 hours is based on a reasonable charge, not the scheduled amount.

This Summary of Benefits is a brief review of benefits. Once enrolled, members will receive a Combined Evidence of Coverage and Disclosure Form, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.

(40425-C)*low Base Plan (Free)

SISC 80 G $20 Anthem Classic PPO

PPO Benefits

In addition to dollar and percentage copays, members are responsible for deductibles, as described below. Please review the deductible information to know if a deductible applies to a specific covered service. 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. Members are also 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.

Explanation of Covered Expense

Plan payments are based on covered expense, which is the lesser of the charges billed by the provider or the following:

PPO Providers—PPO negotiated rates. Members are not responsible for the difference between the provider's usual charges & the negotiated amount.

Non-PPO Providers—For non-emergency services, the scheduled amount. For emergency services, same as other health care providers

Other Health Care Providers *(includes those not represented in the PPO provider network)*—The customary & reasonable charge for professional services or the reasonable charge for institutional services.

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.

Calendar year deductible for all providers	$500/member; $1,000//family	
Co-pay for emergency room services	$100/visit *(waived if admitted directly from ER)*	
Annual Out-of-Pocket Maximums		
All Providers	$1,000/member/year; $3,000/family/year	
The following do not apply to out-of-pocket maximums: deductibles listed above; non-covered expense, and co-pays. After a member reaches the out-of-pocket maximum, the member remains responsible for deductibles listed above; for non-PPO providers & other health care providers, costs in excess of the covered expense; amounts related to a transplant unrelated donor search, and office visit co-pays.		
Lifetime Maximum	None	
Covered Services	**PPO: Per Member Copay**	**Non-PPO: Per Member Copay[1]**
Hospital Medical Services *(subject to utilization review for inpatient services; waived for emergency admissions)*		
➢ Semi-private room, meals & special diets, & ancillary services	20%	0% *(benefit limited to $600/day)*
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	20%	50%
Ambulatory Surgical Centers		
➢ Outpatient surgery, services & supplies	20%	0% *(benefit limited to $350/day)*
Hemodialysis		
➢ Outpatient hemodialysis services & supplies	20%	0% *(benefit limited to $350/day)*
Skilled Nursing Facility *(subject to utilization review)*		
➢ Semi-private room, services & supplies *(limited to 100 days/calendar year)*	20%	0% *(benefit limited to $600/day)*
Hospice Care		
➢ Inpatient or outpatient services; family bereavement services	20%[2]	

[1]The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount. Member is responsible for all charges exceeding the scheduled amount.

[2] These providers are not represented in the Anthem Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
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; not covered while member receives hospice care)*	20%	0%
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	20%	0% *(benefit limited to $600/day)*
Physician Medical Services		
➢ Office & home visits	$20/visit[2] *(deductible waived)*	0%
➢ Hospital & skilled nursing facility visits	20%	0%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	20%	0%
Diagnostic X-ray & Lab		
➢ MRI, CT scan, PET scan & nuclear cardiac scan *(subject to utilization review)*	20%	0%
➢ Other diagnostic x-ray & lab	20%	0%
Well Baby & Well-Child Care for Dependent Children		
➢ Routine physical examinations *(birth through age six)*	No co-pay *(deductible waived)*	0% *(benefit limited to $20/exam)*
➢ Immunizations *(birth through age six)*	0% *(deductible waived)*	0% *(benefit limited to $12/immunization)*
Physical Exams for Members Ages Seven & Older		
➢ Routine physical exams, immunizations, diagnostic X-ray & lab for routine physical exam	0% No co-pay *(deductible waived)*	Not covered
Adult Preventive Services *(including mammograms, Pap smears, prostate cancer screenings & colorectal cancer screenings)*	0% *(deductible waived)*	0%
Physical Therapy, Physical Medicine & Occupational Therapy, including Chiropractic Services *(subject to medical necessity review administered by American Specialty Health - ASH)*	20%	0%
Speech Therapy		
➢ Outpatient speech therapy following injury or organic disease	20%	0%
Acupuncture		
➢ Services for the treatment of disease, illness or injury *(limited 12 visits/calendar year)*	20%[3] *(benefit limited to $50/visit)*	0%[3] *(benefit limited to $25/visit)*
Temporomandibular Joint Disorders		
➢ Splint therapy & surgical treatment	20%	0%
Pregnancy & Maternity Care		
➢ Physician office visits	$20/visit[2] *(deductible waived)*	0%
➢ Prescription drug for elective abortion *(mifepristone)*	20%	0%
Normal delivery, cesarean section, complications of pregnancy & abortion *(newborn routine nursery care covered when natural mother is subscriber or spouse/domestic partner)*		
➢ Inpatient physician services	20%	0%
➢ Hospital & ancillary services	20%	0% (benefit limited to $600/day)

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount. Member is responsible for all charges exceeding the scheduled amount.

[2] The dollar copay applies only to the visit itself. An additional 20% copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

[3] Acupuncture services can be performed by a certified acupuncturist (C.A.), a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a podiatrist (D.P.M.), or a dentist (D.D.S.).

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Organ & Tissue Transplants *(subject to utilization review; specified organ transplants covered only when performed at Centers of Medical Excellence [CME])*		
➢ Inpatient services provided in connection with non-investigative organ or tissue transplants	20%	Not covered
➢ Transplant travel expense for an authorized, specified transplant at a *CME* *(recipient & companion transportation limited to $10,000 per transplant)*	No copay *(deductible waived)*	
➢ Unrelated donor search, limited to $30,000 per transplant		
Bariatric Surgery *(subject to utilization review; medically necessary surgery for weight loss, only for morbid obesity covered only when performed at Centers of Medical Excellence [CME])*		
➢ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity	20%	Not covered
➢ Bariatric travel expense when member's home is 50 miles or more from the nearest Bariatric *CME* *(transportation to & from CME, hotel accommodations and incidentals for member and companion limited to a maximum reimbursement of $500 total per trip. Hotel accommodations for member and companion double occupancy limited to $174 per day or billed amount; which ever is less. Mileage is reimbursed based on Internal Revenue mileage rates at the time of travel. Number of trips is unlimited based on medical necessity. Lodging expenses for band adjustments and expenses for tobacco, alcohol and meals are excluded.)*	No copay *(deductible waived)*	
Diabetes Education Programs *(requires physician supervision)*		
➢ Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	$20/visit *(deductible waived)*	0%
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; & therapeutic shoes & inserts for members with diabetes	20%	0%
Durable Medical Equipment		
➢ Rental or purchase of DME including hearing aids, dialysis equipment & supplies	20%	0%
Hearing Aid		
➢ Supplies and equipment *(limited to $700 per 24 months)*	20%	0%
Related Outpatient Medical Services & Supplies		
➢ Ground or air ambulance transportation, services & disposable supplies	20%[2]	
➢ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	20%[2]	
➢ Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)*	20%[2]	

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount. Member is responsible for all charges exceeding the scheduled amount.

[2] These providers are not represented in the Anthem Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Specialty Pharmacy Drugs *(utilization review may be required)*		
➢ Specialty pharmacy drugs filled through the specialty pharmacy program *(limited to 30-day supply; not covered if benefits are provided through prescription drug benefits, if applicable)*	20%	Not covered[2]
If member does not get specialty pharmacy drugs from the specialty pharmacy program, member will not receive any specialty pharmacy drug benefits under this plan, unless the member qualifies for an exception as specified in the EOC.		
Emergency Care		
➢ Emergency room services & supplies *($100 co-pay waived if admitted)*	20%	0%
➢ Inpatient hospital services & supplies	20%	20% first 48 hours; 0% limited to $600/day after 48 hours (unless member can not be moved safely)
➢ Physician services	20%	20%[3]
Mental or Nervous Disorders and Substance Abuse		
Inpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	20%	0% *(benefit limited to $600/day)*
➢ Inpatient physician visits	20%	0%
Outpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	20%	50%
➢ Outpatient physician visits *(pre-service review required after the 12th visit)*	$20 *(deductible waived)*	0%

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount. Member is responsible for all charges exceeding the scheduled amount.

[2] 20% copay if member or non-PPO physician obtains drug from Specialty Pharmacy Program; otherwise, not covered.

[3] The allowable rate for emergency within 48 hours is based on a reasonable charge, not the scheduled amount.

This Summary of Benefits is a brief review of benefits. Once enrolled, members will receive a Combined Evidence of Coverage and Disclosure Form, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.