Your Summary of Benefits

SCCSIG HSA Plan

Modified Anthem PPO HSA Embedded 2700/3000 0/30

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.

This Anthem PPO plan is an innovative type of coverage that allows an member to use a Health Savings Account to pay for routine medical care. The program also includes traditional health coverage, similar to a typical health plan, that protects the member against large medical expenses. The member can spend the money in the HSA account the way the member wants on routine 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.

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 The family deductible is embedded meaning the cost shares of one family member will be applied to individual deductible; in addition, amounts for all family members apply to the family deductible. One family member will contribute no more than the individual amount.)*

• Participating Providers, Participating Pharmacy & Other Health Care Providers	$2,700/individual member; $5,400/family
• Non-Participating Providers & Non-Participating Pharmacy	$3,000/individual 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. The family out-of-pocket maximum is embedded meaning the cost shares of one family member will be applied to individual out-of-pocket; in addition, amounts for all family members apply to the family out-of-pocket. One family member will contribute no more than the individual amount.*)

• Participating Providers, Participating Pharmacy & Other Health Care Providers	$2,700/individual member; $5,400/family
• Non-Participating Providers & Non-Participating Pharmacy	$7,000/individual member; $14,000/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)*	No copay	30%
• Hospital & skilled nursing facility visits	No copay	30%
• Surgeon & surgical assistant; anesthesiologist or anesthetist	No copay	30%
• Drugs administered by a medical provider *(certain drugs are subject to utilization review)*	No copay	30%

Covered Services	In-Network	Out-of-Network[§§]
Diabetes Education Programs *(requires physician supervision)*		
◦ Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	No copay	30%
Physical Therapy, Physical Medicine & Occupational Therapy, including Chiropractic Services (*limited to 24 visits/calendar year*)	No copay	30%
Speech Therapy		
◦ Outpatient speech therapy	No copay	30%
Acupuncture		
◦ Services for the treatment of disease, illness or injury *(limited 12 visits/calendar year)*	No copay[†]	30%[†]
Diagnostic X-ray & Lab		
◦ Other diagnostic x-ray & lab	No copay	30%
Advanced Imaging *(subject to utilization review)*	No copay	30% *(benefit limited to $800/procedure)*
Urgent Care *(physician services)*	No copay	30%
Emergency Care		
◦ Emergency room services & supplies	No copay	No copay
◦ Physician services	No copay	No copay
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	No copay	30%
◦ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	No copay	30%
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)*	No copay	30%

Covered Services	In-Network	Out-of-Network[§§]
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)*	No copay	In an emergency or with an authorized referral: No copay; Non-emergency: 30%
• Blood transfusions, blood processing & the cost of unreplaced blood & blood products[††]	No copay	30%
• Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)* [††]	No copay	30%
Ambulatory Surgical Centers *(certain surgeries are subject to utilization review)*		
• Outpatient surgery, services & supplies	No copay	30% *(benefit limited to $350/admit)*
Pregnancy & Maternity Care		
• Physician office visits	No copay	30%
• Prescription drug for abortion *(mifepristone)*	No copay	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)*	No copay	30%
• Inpatient physician visits	No copay	30%
• Outpatient facility care	No copay	30%
• Physician office visits *(Behavioral Health treatment for Autism or Pervasive Development disorders require pre-service review)*	No copay	30%
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. Hearing aid benefit limited to one hearing aid per ear every three years)*	No copay	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)*	No copay	30%

Covered Services	In-Network	Out-of-Network[§§]
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	No copay	30% *(benefit limited to $600/day)*
Hemodialysis		
• Outpatient hemodialysis services & supplies	No copay	30% *(benefit limited to $350/visit for free standing hemodialysis center)*
Hospice Care		
• Inpatient or outpatient services; family bereavement services	No copay	30%
Bariatric Surgery *(subject to utilization review; covered only when performed at a Centers of Medical Excellence [CME] for California; Blue Distinction Centers for Speciality Care [BDCSC] for out of California)*		
• Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity	No copay	Not covered[‡‡]
• Travel expenses for an authorized, specified surgery *(recipient & companion transportation limited to $3,000 per surgery)*	No copay	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] and CME for out of California)*		
• Inpatient services provided in connection with non-investigative organ or tissue transplants	No copay	Not covered[‡‡]
• Transplant travel expense for an authorized, specified transplant *(recipient & companion transportation limited to $10,000 per transplant)*	No copay	Not covered[‡‡]
• Unrelated donor search, limited to $30,000 per transplant		

Covered Services	In-Network	Out-of-Network[§§]
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	No copay	30%
Outpatient Prescription Drug Benefits (*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	No copay *(deductible waived)*	
• Female oral contraceptives generic, single source, and multi-source brand	No copay *(deductible waived)*	
• Tier 1 drugs *(includes diabetic supplies)*	$10	
• Tier 2 drugs	$30[f]	
• Tier 3 drugs *(includes compound drugs)*	$50[f]	
• Tier 4 drugs [§]	30% coinsurance up to a $250 maximum for a 30 day supply	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)*

Covered Services	In-Network	Out-of-Network[§§]
Home Delivery Program		
○ Female oral contraceptives generic, single source, and multi-source brand	No copay (*deductible waived)*	
○ Tier 1 drugs *(includes diabetic supplies)*	$10	
○ Tier 2 drugs	$60[f]	
○ Tier 3 drugs	$100[f]	
○ Tier 4 drugs [§]	30% coinsurance up to a $250 maximum for a 30 day supply	
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*)	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	
○ Home Delivery	90-day supply	
○ Specialty Pharmacy	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 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).
- Drugs that have Food and Drug Administration (FDA) labeling for self-administration
- All compound prescription drugs that contain at least one covered prescription ingredient
- 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 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).

† 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.).

‡ 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.

ƒ 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.

†† 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.

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

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Modified Infertility Treatment Rider

To Accompany Blue Cross PPO Plans

Blue Cross of California offers the option to choose infertility treatment with all medical plans.

Infertility Treatment Benefit

Medical care that is covered, when provided for the diagnosis and treatment of infertility, shall be those services and supplies specified in the Evidence of Coverage (EOC) as covered for the treatment of illness generally. The member must be under the direct care and treatment of a physician for infertility. Benefits are NOT payable for laboratory medical procedures involving the actual in vitro fertilization process.

The member will not be required to satisfy the Calendar Year Deductible specified in the EOC before we pay benefits for the treatment of infertility. Benefits are paid at **50%** of covered expense incurred. In no event will benefit payments exceed **$4,000** for all covered expense incurred in a calendar year.

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