Your summary of benefits

Anthem BlueCross

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Your Plan: BMC Corporate - Core HSA

Your Network: National PPO (BlueCard 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.

BMC Contributions	Download the Mobile Health Consumer app and complete a Health Risk Assessment to earn $100 into your HSA	Complete a routine physical/wellness exam and earn $100 into your HSA	Complete wellness activities through Sonic Boom and receive $100 in wellness dollars

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-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.* *In-Network Providers and Non-Network Providers deductibles are combined. Satisfying one helps satisfy the other.* *Family amount can be satisfied by a family member or a combination of family members. Non-embedded.*	$2,200 single / $4,400 family	$4,400 single / $8,800 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.* *In-Network Providers and Non-Network Providers Out of Pocket are combined. Satisfying one helps satisfy the other.* *Family amount can be satisfied by any combination of family members but an individual would never satisfy more than their own individual amount. Embedded.*	$6,000 single / $12,000 family	$12,000 single / $24,000 family
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	20% coinsurance	50% coinsurance

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Specialist care visit	20% coinsurance	50% coinsurance
Prenatal and Post-natal Care	20% coinsurance	50% coinsurance
Other practitioner visits:		
Retail health clinic	20% coinsurance	50% coinsurance
LiveHealth Online	20% coinsurance	Not covered
Spinal Manipulation *Coverage for In-Network Provider and Non-Network Provider combined is limited to 25 visit limit per calendar Year for Spinal Manipulations.*	20% coinsurance	50% coinsurance
Acupuncture *Coverage for In-Network Provider and Non-Network Provider combined is limited to 24 visit limit per calendar Year.*	20% coinsurance	50% coinsurance
Other services in an office:		
Allergy testing	20% coinsurance	50% coinsurance
Chemo/radiation therapy	20% coinsurance	50% coinsurance
Hemodialysis	20% coinsurance	50% coinsurance
Prescription drugs *For the drugs itself dispensed in the office thru infusion/injection*	20% coinsurance	50% coinsurance
Diagnostic Services		
Lab:		
Office	20% coinsurance	50% coinsurance
Freestanding Lab	20% coinsurance	50% coinsurance
Outpatient Hospital	20% coinsurance	50% coinsurance
X-ray:		
Office	20% coinsurance	50% coinsurance
Freestanding Radiology Center	20% coinsurance	50% coinsurance
Outpatient Hospital	20% coinsurance	50% coinsurance
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		

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Office	20% coinsurance	50% coinsurance
Freestanding Radiology Center	20% coinsurance	50% coinsurance
Outpatient Hospital	20% coinsurance	50% coinsurance
Emergency and Urgent Care		
Emergency room facility services	20% coinsurance	20% coinsurance
Emergency room doctor and other services	20% coinsurance	20% coinsurance
Ambulance (air and ground)	20% coinsurance	20% coinsurance
Urgent Care (office setting)	20% coinsurance	50% coinsurance
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit	20% coinsurance	50% coinsurance
Facility visit:		
Facility fees	20% coinsurance	50% coinsurance
Outpatient Surgery		
Facility fees:		
Hospital	20% coinsurance	50% coinsurance
Freestanding Surgical Center	20% coinsurance	50% coinsurance
Doctor and other services	20% coinsurance	50% coinsurance
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)		
Facility fees (for example, room & board) *Failure to obtain preauthorization may result in non-coverage or reduced coverage.*	20% coinsurance	50% coinsurance
Doctor and other services	20% coinsurance	50% coinsurance
Recovery & Rehabilitation		
Home health care *Coverage for In-Network Provider and Non-Network Provider combined is*	20% coinsurance	50% coinsurance

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limited to 100 day limit per calendar Year.		
Rehabilitation services (for example, physical/speech/occupational therapy): Office *No visit limit for In-Network Provider and Non-Network Provider per calendar Year for Physical, Speech and Occupational Therapy combined.* Outpatient hospital Habilitation services	20% coinsurance 20% coinsurance 20% coinsurance	50% coinsurance 50% coinsurance 50% coinsurance
Cardiac rehabilitation Office Outpatient hospital	20% coinsurance 20% coinsurance	50% coinsurance 50% coinsurance
Skilled nursing care (in a facility) *Coverage for In-Network Provider and Non-Network Provider combined is limited to 100 day limit per calendar Year.*	20% coinsurance	50% coinsurance
Hospice *Bereavement counseling covered.*	20% coinsurance	50% coinsurance
Durable Medical Equipment *Failure to obtain preauthorization may result in non-coverage or reduced coverage.*	20% coinsurance	50% coinsurance
Prosthetic Devices	20% coinsurance	50% coinsurance

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Notes:

- Annual Out-of-Pocket Maximums includes deductible, copays, coinsurance and prescription drug.
- 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.
- For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement is based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.
- 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.
- 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.
- 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).
- 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.
- Additional visits maybe authorized if medically necessary. Pre-service review must be obtained prior to receiving the additional services.
- All medical services subject to a coinsurance are also subject to the annual medical deductible.
- 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 Anthem website or call customer service.
- Freestanding Lab and Radiology Center is defined as services received in a non-hospital based facility.

- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- 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.
- Skilled Nursing Facility day limit does not apply to mental health and substance abuse.
- Applied behavior analysis treatment for autism spectrum disorder is covered according to state law.