Your summary of benefits

Anthem BlueCross

Your Plan: Lam Research Base PPO Plan

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 Summary Plan Description (SPD). If there is a difference between this summary and the Summary Plan Description (SPD), the Summary Plan Description (SPD), will prevail.

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. .* *In-Network Providers and Non-Network Providers deductibles are combined.* *Satisfying one helps satisfy the other.* **Additional deductible: *$500 for*** *non-PPO in-patient hospital or residential treatment center stay if utilization review not obtained (waived for emergency admission).*	$1,300 single / $2,600 family	$2,600 single / $5,200 family
Out-of-Pocket Limit *(includes deductible)* *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.*	$3,000 single / $6,000 family	$6,000 single / $12,000 family
Preventive care/screening/immunization	No charge *(deductible waived)*	30% coinsurance
Doctor Home and Office Services		
Primary care visit to treat an injury or illness	$25 copay/visit *(deductible waived)*	30% coinsurance
Specialist care visit	$30 copay/visit *(deductible waived)*	30% coinsurance
Other practitioner visits: LiveHealth Online	$25 copay/visit *(deductible waived)*	Not applicable

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Other practitioner visits:		
Chiropractic care *Limited to 36 visits/calendar year.*	$30 copay/visit *(deductible waived)*	30% coinsurance
Acupuncture *Limited to 24 visits/calendar year.*	No copay *(deductible waived)*	30% coinsurance
Physical Therapy, Physical Medicine & Occupational Therapy *Limited to 36 visits/calendar year.*	$30 copay/visit *(deductible waived)*	30% coinsurance
Speech Therapy *Outpatient speech therapy following injury or organic disease.*	15% coinsurance	30% coinsurance
Mental Health outpatient visits	$25 copay/visit *(deductible waived)*	30% coinsurance
Other services in an office:		
Chemo/radiation therapy	15% coinsurance	30% coinsurance
Hemodialysis	15% coinsurance	30% coinsurance
Diagnostic Services		
Lab/X-ray services	15% coinsurance	30% coinsurance
Emergency *(life & limb threatening)*		
Emergency room services and supplies *(copay waived if admitted)*	$150 copay/visit	$150 copay/visit
Ambulance *(ground or air)*	15% coinsurance	15% coinsurance
Urgent Care	$30 copay/visit	30% coinsurance
Temporomandibular Joint Disorders		
Splint therapy & surgical treatment	15% coinsurance	30% coinsurance

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Outpatient Surgery	15% coinsurance	30% coinsurance
Hospital Stay (all inpatient stays including mental / behavioral health, and substance abuse) *Utilization review required*		
Facility fees (room & board)	15% coinsurance	30% coinsurance
Doctor and other services	15% coinsurance	30% coinsurance
Recovery & Rehabilitation		
Home health care *(Limited to 100 day limit/calendar year; one visit by a home health aide equals four hours or less; not covered while member receives hospice care)*	15% coinsurance	30% coinsurance
Cardiac rehabilitation		
Office/Outpatient Hospital	15% coinsurance	30% coinsurance
Skilled nursing care (in a facility) *(Limited to 60 days/calendar year)*	15% coinsurance	30% coinsurance
Hospice *(Bereavement counseling covered)*	15% coinsurance	30% coinsurance
Durable Medical Equipment *Rental or purchase of DME including hearing aids, dialysis equipment & supplies. (hearing aid benefit available for one hearing aid per ear every three years)*	15% coinsurance	30% coinsurance
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)*	15% coinsurance	30% coinsurance
Ambulatory Surgical Centers *Outpatient surgery, services and supplies*	15% coinsurance	30% coinsurance *(benefit limited to $350/day)*

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Infertility Treatment *Includes coverage for in-vitro fertilization, artificial insemination, (AFT) GIFT and ZIFT); limited to $25,000 per lifetime*	15% coinsurance	30% coinsurance
Organ & Tissue Transplants *(subject to utilization review; specified transplants covered only when performed at Centers of Medical Excellence-CME; Blue Distinction Centers for Specialty Care-BDCSC)*		
Inpatient services provided in connection with non-investigative organ or tissue transplants	15% coinsurance	
Transplant travel expense for an authorized, specified transplant (recipient & companion transportation limited to $10,000/transplant	15% coinsurance	

Notes:

- This Summary of Benefits has been updated to comply with federal requirements, including applicable provisions of 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).
- Annual Out-of-Pocket Maximums includes copays, coinsurance and prescription drug.
- Inpatient services for Non-PPO facilities 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, a $500 penalty applies.
- 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.
- For services rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement is based on the maximum allowable amount. Members may be responsible for any amount in excess of the maximum allowable amount.
- All medical services subject to a coinsurance are also subject to the annual medical deductible.
- For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to Anthem website or call customer service.
- 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.
- This plan includes an embedded accumulation for the deductible and out-of-pocket maximum. This means that the family amounts can be met by any combination of amounts from any family member, however an individual member of a family only has to satisfy the individual deductible or out of pocket amounts.