

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 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

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
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center	\$250/admission (<i>waived for emergency admission</i>)
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center if utilization review not obtained	\$250/admission (<i>waived for emergency admission</i>)
Deductible for emergency room services	\$100/visit (<i>waived if admitted directly from ER</i>)
Annual Out-of-Pocket Maximums (<i>no cross application</i>)	
PPO Providers & Other Health Care Providers	\$3,000/member/year; \$6,000/family/year
Non-PPO Providers	\$10,000/member/year; \$20,000/family/year

The following do not apply to out-of-pocket maximums: non-covered expense. After a member reaches the out-of-pocket maximum, the member remains responsible for non-PPO providers & other health care providers, costs in excess of the covered expense

Lifetime Maximum	Unlimited	
Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay¹
Hospital Medical Services (<i>subject to utilization review for inpatient services; waived for emergency admissions</i>)		
➤ Semi-private room, meals & special diets, & ancillary services	\$250/admission + 20%	40% (<i>benefit limited to \$600/day</i>)
➤ Outpatient medical care, surgical services & supplies (<i>hospital care other than emergency room care</i>)	20%	40% (<i>benefit limited to \$600/day</i>)
Ambulatory Surgical Centers		
➤ Outpatient surgery, services & supplies	\$125/surgery + 20%	40% (<i>benefit limited to \$350/day</i>)
Skilled Nursing Facility (<i>subject to utilization review</i>)		
➤ Semi-private room, services & supplies (<i>limited to 100 days/calendar year; limit does not apply to mental health and substance abuse</i>)	20%	20%
Hospice Care (<i>subject to utilization review</i>)		
➤ Inpatient or outpatient services for members with up to one year life expectancy; family bereavement services	No copay ²	

¹ The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on 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 <i>(subject to utilization review)</i>		
➤ Services & supplies from a home health agency <i>(limited to combined 100 prior authorized visits/calendar year, one visit by a home health aide equals four hours or less; not covered while member receives hospice care)</i>	20%	20% with authorization
Home Infusion Therapy <i>(subject to utilization review)</i>		
➤ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	20%	20%
Physician Medical Services		
➤ Office & home visits	\$35/visit ² <i>(deductible waived)</i>	40%
➤ Hospital & skilled nursing facility visits	20%	40%
➤ Surgeon & surgical assistant; anesthesiologist or anesthesiologist	20%	40%
➤ Drugs administered by a medical provider <i>(Certain drugs are subject to utilization review)</i>	20%	40%
Diagnostic X-ray & Lab		
➤ MRI, CT scan, PET scan & nuclear cardiac scan <i>(subject to utilization review)</i>	20%	40%
➤ Other diagnostic x-ray & lab	No copay	40%
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 <i>(deductible waived)</i>	40%
Physical Therapy, Physical Medicine & Occupational Therapy	\$25/visit <i>(deductible waived)</i>	40%
Chiropractic Services <i>(up to 12 visits/calendar year; additional visits may be approved, if medically necessary)</i>	\$25/visit <i>(deductible waived)</i>	40%
Speech Therapy		
➤ Outpatient speech therapy following injury or organic disease	\$35/visit <i>(deductible waived)</i>	40%
Acupuncture		
➤ Services for the treatment of disease, illness or injury <i>(limited to 20 visits/calendar year)</i>	20% ³	40% ³
Temporomandibular Joint Disorders		
➤ Splint therapy & surgical treatment	20%	40%
Pregnancy & Maternity Care		
➤ Physician office visits	\$35/visit ² <i>(deductible waived)</i>	40%
➤ Prescription drug for elective abortion (<i>mifepristone</i>)	20%	Not covered
Normal delivery, cesarean section, complications of pregnancy & abortion		
➤ Inpatient physician services	20%	40%
➤ Hospital & ancillary services	\$250/admission + 20%	40% <i>(benefit limited to \$600/day)</i>
➤ Female Sterilization <i>(including tubal ligation and counseling/consultation)</i>	No copay	Not covered
➤ Male Sterilization	20%	Not covered
➤ Family Planning counseling	\$35/visit <i>(deductible waived)</i>	Not covered

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²The 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.

³Acupuncture 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 <i>(subject to utilization review; specified organ transplants covered only when performed at a Center of Expertise [COE])</i>		
➤ Inpatient services provided in connection with non-investigative organ or tissue transplants		\$250/admission + 20%
➤ Transplant travel expense for an authorized, specified transplant at a COE <i>(recipient & companion transportation limited to 6 trips/episode & \$250/person/trip for round-trip coach airfare, hotel limited to 1 room double occupancy & \$100/day for 21 days/trip, other expenses limited to \$25/day/person for 21 days/trip, donor transportation limited to 1 trip/episode & \$250 for round-trip coach airfare, hotel limited to \$100/day for 7 days, other expenses limited to \$25/day for 7 days)</i>		No copay <i>(deductible waived)</i>
Bariatric Surgery <i>(subject to utilization review; medically necessary surgery for weight loss, only for morbid obesity, covered only when performed at a Center of Expertise [COE])</i>		
➤ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity		\$250/admission + 20%
➤ Bariatric travel expense when member's home is 50 miles or more from the nearest Bariatric CME <i>(member's transportation to & from CME limited to \$130/person/trip for 3 trips [pre-surgical visit, initial surgery & one follow-up visit]; one companion's transportation to & from CME limited to \$130/person/trip for 2 trips [initial surgery & one follow-up visit]; hotel for member & one companion limited to one room double occupancy & \$100/day for 2 days/trip, or as medically necessary, for pre-surgical & follow-up visit; hotel for one companion limited to one room double occupancy & \$100/day for duration of member's initial surgery stay for 4 days; other reasonable expenses limited to \$25/day/person for 4 days/trip)</i>		No copay <i>(deductible waived)</i>
Diabetes Education Programs <i>(requires physician supervision)</i>		
➤ Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	\$35/visit <i>(deductible waived)</i>	40%
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	20%	40%
Durable Medical Equipment		
➤ Rental or purchase of DME including , dialysis equipment & supplies, home medical equipment, prosthetic/orthotics <i>(hearing aids benefit available for one hearing aid per ear every three years; breast pump and supplies are covered under preventive care at no charge for in-network)</i>	20%	20%
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 <i>(self-donated blood collection, testing, processing & storage for planned surgery)</i>		20% ²

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Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay ¹
Emergency Care		
➤ Emergency room services & supplies (<i>\$100 deductible waived if admitted</i>)	20%	20%
➤ Inpatient hospital services & supplies	\$250/admission + 20%	\$250/admission + 20%
➤ Physician services	20%	20%
Mental or Nervous Disorders and Substance Abuse		
➤ Inpatient facility care (<i>subject to utilization review; waived for emergency admissions</i>)	\$250/admission + 20%	40% (<i>benefit limited to \$600/day</i>)
➤ Inpatient physician visits	20%	40%
➤ Outpatient facility care	20%	40%
➤ Physician office visits (<i>Behavioral Health treatment for Autism & Pervasive Development disorders requires pre-service review</i>)	\$35/visit ³ (<i>deductible waived</i>)	40%

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³ 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.

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.

Anthem believes this plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections of the Affordable Care Act apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Anthem at the telephone number printed on the back of your member identification card, or contact your group benefits administrator if you do not have an identification card. For ERISA plans, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For nonfederal governmental plans, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Classic PPO Plan Exclusions and Limitations

Not Medically Necessary. Services or supplies that are not medically necessary, as defined.

Experimental or Investigative. Any experimental or investigative procedure or medication. But, if member is denied benefits because it is determined that the requested treatment is experimental or investigative, the member may request an independent medical review, as described in the Evidence of Coverage (EOC).

Outside the United States. Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with urgent care or an emergency.

Crime or Nuclear Energy. Conditions that result from (1) the member's commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for the treatment of illness or injury arising from the release of nuclear energy.

Not Covered. Services received before the member's effective date. Services received after the member's coverage ends, except as specified as covered in the EOC.

Excess Amounts. Any amounts in excess of covered expense or the lifetime maximum.

Work-Related. Any injury, condition or disease arising out of employment for which benefits or payments are covered by any worker's compensation law or similar law. If we provide benefits for such injuries, conditions or diseases we shall be entitled to establish a lien or other recovery under section 4903 of the California Labor Code or any other applicable law, as specified in the EOC/Certificate.

Government Treatment. Any services the member actually received that were provided by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if the member is not required to pay for them or they are given to the member for free.

Services of Relatives. Professional services received from a person living in the member's home or who is related to the member by blood or marriage, except as specified as covered in the EOC.

Voluntary Payment. Services for which the member has no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:

1. it must be internationally known as being devoted mainly to medical research;
2. at least 10% of its yearly budget must be spent on research not directly related to patient care;
3. at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. it must accept patients who are unable to pay; and
5. two-thirds of its patients must have conditions directly related to the hospital's research.

Private Contracts. Services or supplies provided pursuant to a private contract between the member and a provider, for which reimbursement under Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. Mental or nervous disorders or substance abuse, including rehabilitative care in relation to these conditions, except as specified as covered in the EOC.

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental implants, dental services, extraction of teeth, treatment to the teeth or gums, or treatment to or for any disorders for the temporomandibular (jaw) joint, except as specified as covered in the EOC. Cosmetic dental surgery or other dental services for beautification.

Hearing Aids or Tests

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, as specified as covered in the EOC. Eyeglasses or contact lenses, except as specified as covered in the EOC.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a home health agency, hospice, or home infusion therapy provider, as specified as covered in the EOC.

Outpatient Speech Therapy. Outpatient speech therapy, except as specified as covered in the EOC.

Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.

Commercial Weight Loss Programs. Weight loss programs, whether or not they are pursued under medical or *physician* supervision, unless specifically listed as covered in this *plan*.

This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

This exclusion does not apply to *medically necessary* treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as described in the Evidence of Coverage (EOC).

Sterilization Reversal.

Infertility Treatment. Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal and gamete intrafallopian transfer.

Surrogate Mother Services. For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient, or therapeutic shoes and inserts designed to treat foot complications due to diabetes, as specifically stated in the EOC.

Air Conditioners. Air purifiers, air conditioners or humidifiers.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility or custodial care or rest cures, except as specified as covered in the EOC.

Health Club Memberships. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a *physician*. This exclusion also applies to health spas.

Personal Items. Any supplies for comfort, hygiene or beautification.

Educational Services. Services, supplies or room and board for teaching, vocational, or self-training purposes. This includes, but is not limited to boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based. This Exclusion does not apply to Medically Necessary services to treat Severe Mental Illness or Serious Emotional Disturbances of a Child as required by state law.

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as provided in this *plan* or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not requirement either a written prescription or dispensing by a licensed pharmacist.

Telephone and Facsimile Machine Consultations. Consultations provided by telephone or facsimile machine.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specified as covered in the EOC.

Acupuncture. Acupuncture treatment, except as specified as covered in the EOC. Acupressure or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Physical Therapy or Physical Medicine. Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement or as specified as covered in the EOC.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specified as covered in the Certificate. Any non-prescription, over-the-counter patent or proprietary drug or medicine. Cosmetics, health or beauty aids.

Specialty Pharmacy Drugs. Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but, which are obtained from a retail pharmacy, are not covered by this plan. **Member will have to pay the full cost of the specialty pharmacy drugs obtained from a retail pharmacy that should have been obtained from the specialty pharmacy program.**

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specified as covered in the EOC.

Diabetic Supplies. Prescription and non-prescription diabetic supplies except as specified as covered in the EOC.

Private Duty Nursing. Private duty nursing services given in a Hospital or Skilled Nursing Facility. Private duty nursing services are a Covered Service only when given as part of the "Home Care Services" benefit.

Residential accommodations. Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center. This Exclusion includes procedures, equipment, services, supplies or charges for the following:

- Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmity, school infirmity, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.

This Exclusion does not apply to Medically Necessary services to treat Severe Mental Illness or Serious Emotional Disturbances of a Child as required by state law.

Wilderness. Wilderness or other outdoor camps and/or programs. This Exclusion does not apply to Medically Necessary services to treat Severe Mental Illness or Serious Emotional Disturbances of a Child as required by state law.

Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition, except as specified as covered in the Certificate. This exclusion will not apply to cardiac rehabilitation programs approved by us.

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Medicare. For which benefits are payable under Medicare Parts A and/or B, or would have been payable if you had applied for Parts A and/or B, except as listed in this Booklet or as required by federal law, as described in the section titled "Medicare" in "General Provisions." If you do not enroll in Medicare Part B when you are eligible, you may have large out-of-pocket costs. Please refer to Medicare.gov for more details on when you should enroll and when you are allowed to delay enrollment without penalties.

Clinical Trial Non-Covered Services. Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.

Clinically-Equivalent Alternatives. Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. "Clinically equivalent" means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at www.anthem.com. If you or your Doctor believes you need to use a different Prescription Drug, please have your Doctor or pharmacist get in touch with us. We will cover the other Prescription Drug only if we agree that it is Medically Necessary and appropriate over the clinically equivalent Drug. We will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.

Third Party Liability — Anthem Blue Cross is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

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 coverages do not exceed 100% of the covered expense.

This plan includes custom benefits that may supersede some of the information included in the Limitations and Exclusions provided here. Please see your EOC for full details on your covered benefits.

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