Your Summary of Benefits
PLAN-B $0 Anthem Classic PPO

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.

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.

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.

PPO 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-PPO Providers—For non-emergency care, 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. Members are responsible for the difference between the provider's usual charges & the maximum allowed amount.

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. 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 *(4th quarter carryover applies)(Deductible applies to out-of-pocket maximum)*	$0/member; $0/family
Co-pay for emergency room services	$100/visit ***(waived if admitted directly from ER)***
Annual Out-of-Pocket Maximums	
PPO Providers Only*	$1,000/member; $3,000/family

**Member copayments and coinsurance for Emergency Medical Care with a Non-PPO Provider also apply to the PPO Out-of-Pocket Maximums.*

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 costs in excess of the covered expense.

Lifetime Maximum	**Unlimited**

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
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	Not covered

Physician Medical Services o Office & home visits o Hospital & skilled nursing facility visits o Surgeon & surgical assistant; anesthesiologist or anesthetist o Drugs administered by a medical provider *(certain drugs are subject to utilization review)*	$0/visit[2] 0% 0% 0%	See footnote 1 See footnote 1 See footnote 1 See footnote 1
Diabetes Education Programs ***(requires physician supervision)*** o Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	$0/visit[2]	See footnote 1

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Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Physical Therapy, Physical Medicine & Occupational Therapy, including Chiropractic Services *(subject to medical necessity review administered by American Specialty Health- ASH)*	0%	Not Covered
Speech Therapy o Outpatient speech therapy	0%	See footnote 1
Acupuncture [3] o Services for the treatment of disease, illness or injury *(limited to 12 visits/calendar year)*	0%	50% of maximum allowed amount[5]
Diagnostic X-ray & Lab o Other diagnostic x-ray & lab	0%	Not Covered
Advanced Imaging ***(subject to utilization review)*** o MRI, CT Scan, PET Scan & nuclear cardiac exam	0%	See footnote 1 *(benefit limited to $800/procedure)*
Urgent Care ***(physician services)***	$0/visit[2]	See footnote 1
Emergency Care o Emergency room services & supplies *($100 co-pay waived if admitted inpatient)* [4] o Inpatient hospital services & supplies [4] o Physician services [4]	0% 0% 0%	0% of maximum allowed amount for true emergency[5] 0% first 48 hours[5]; After 48 hours: all billed amounts exceeding $600/day unless member cannot be moved safely 0% of maximum allowed amount for true emergency[5]
Hospital Medical Services ***(subject to utilization review for inpatient and certain outpatient services; waived for emergency admissions)*** o Semi-private room, medically necessary services & supplies o Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)* o Services and supplies for the following outpatient surgeries are subject to a benefit limit if performed in an outpatient hospital: • Arthroscopy limited to **$4,500** per procedure • Cataract surgery limited to **$2,000** per procedure • Colonoscopy limited to **$1,500** per procedure • Upper GI Endoscopy limited to **$1,000** per procedure • Upper GI Endoscopy with biopsy limited to **$1,250** per procedure	0% 0% 0% up to benefit limit[6]	All billed amounts exceeding $600/day 50% of maximum allowed amount[5] 50% of maximum allowed amount[5]

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)*	0%	All billed amounts exceeding $600/day
Related Outpatient Medical Services & Supplies[5] • 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)* • Blood transfusions, blood processing & the cost of unreplaced blood & blood products • Autologous blood (self-donated blood collection, testing, processing & storage for planned surgery)	$100 copay and then 0% 0% 0%	$100 copay and then 0% maximum allowed amount for true emergency[5] 0% maximum allowed amount[5] 0% maximum allowed amount[5]
Ambulatory Surgical Centers *(certain surgeries are subject to utilization review)* • Outpatient surgery, services & supplies	0%	All billed amounts exceeding $350/day

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Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Pregnancy & Maternity Care • Physician office visits • Prescription drug for abortion *(mifepristone)* Normal delivery, cesarean section, complications of pregnancy & abortion. Refer to the Physician & Hospital Medical Services benefits for both inpatient and outpatient hospital coverage.	$0/visit[2] 0%	See footnote 1 See footnote 1
Mental or Nervous Disorders and Substance Abuse • Inpatient facility care *(subject to utilization review; waived for emergency admissions)* • Inpatient physician visits • Outpatient facility care • Physician office visits *(Behavioral Health treatment for Autism or Pervasive Development disorders requires pre-service review)*	0% 0% 0% $0/visit[2]	All billed amounts exceeding $600/day See footnote 1 50% of maximum allowed amount[5] See footnote 1
Durable Medical Equipment *(may be subject to utilization review)* • Rental or purchase of DME and all medical supplies *(breast pump and supplies are covered under preventive care at no charge for in-network only)* • Hearing aid supplies and equipment *(limited to $700 per 24 months)*	0% 0%	Not Covered 1 See footnote 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)*	0%	All billed amounts exceeding $150/day. See footnote 1
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	0%	All billed amounts exceeding $600/day
Hemodialysis • Outpatient hemodialysis services & supplies	0%	All billed amounts exceeding $350/visit

Hospice Care • Inpatient or outpatient services; family bereavement services	No copay	All billed amounts exceeding the maximum allowed amount
Bariatric Surgery ***(subject to utilization review; covered only when performed at a designated Blue Distinction Center for Specialty Care – Bariatric Surgery)*** • Acute care hospital (inpatient or outpatient) and Ambulatory Surgery Center services provided in connection with medically necessary surgery for weight loss, only for morbid obesity • Travel expenses when member's home is 50 miles or more from the nearest designated Blue Distinction Center for Specialty Care • Bariatric Surgery *($3,000 maximum travel benefit per surgery)*	0% No copay	Not covered Not covered
Hip/Knee/Spine ***(subject to utilization review; covered only when performed at a designated Blue Distinction Plus Center for Specialty Care)*** • Inpatient services provided in connection with medically necessary surgery for hip/knee/spine • Travel expenses when member's home is 50 miles or more from the nearest hip/knee/spine Blue Distinction Plus Center (*$6,000 maximum travel benefit)*	0% No copay	Not covered Not covered
Organ & Tissue Transplants ***(subject to utilization review; specified transplants covered only when performed at a Centers of Medical Excellence [CME] and Blue Distinction Centers for Specialty Care [BDCSC] for California; Blue Distinction Centers for Specialty Care [BDCSC] for out of California)*** • Inpatient services provided in connection with non-investigative organ or tissue transplants • Transplant travel expense for an authorized, specified transplant *(recipient & companion transportation limited to $10,000 per transplant)* • Unrelated donor search, limited to $30,000 per transplant	0% No copay	Not covered Not covered
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 (2 pairs each/calendar year)	0%	Not Covered

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. This Summary of Benefits has been updated to comply with federal 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.

1 When using Non-PPO Providers, members are responsible for any difference between the maximum allowed and actual charges, as well as any deductible& percentage copay.

2 The dollar copay applies only to the visit itself. An additional 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.).

4 The allowable rate for non-PPO emergency care within 48 hours is based on a reasonable charge, not the scheduled amount.

5 These providers may not be represented in the PPO network in the state where the member receives services. Reimbursements for these non-PPO providers are based on a reasonable charge, not the scheduled amount.

6 If you use an in-network outpatient hospital for services subject to the benefit limit, you'll be responsible for your regular deductible and co-insurance PLUS any amount over the maximum benefit, unless your provider receive advance certification that you need to be in an outpatient hospital setting.

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. **Incarceration.** For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

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 any medical benefit 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.

Family Members. Services prescribed, ordered, referred by or given by a member of your immediate family, including your *spouse*, *child*, brother, sister, parent, in-law or self.

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. **Not Specifically Listed.** Services not specifically listed in the plan as covered services.

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 Health Conditions. 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. This exclusion does not apply to the *medically necessary* services to treat *severe mental disorders* or serious emotional disturbances of a child as required by state law.

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

Dental Services or Supplies. For dental treatment, regardless of origin or cause, except as specified below. "Dental treatment" includes but is not limited to preventative care and fluoride treatments; dental x rays, supplies, appliances, dental implants and all associated expenses; diagnosis and treatment related to the teeth, jawbones or gums, including but not limited to:

1. Extraction, restoration, and replacement of teeth; 2. Services to improve dental clinical outcomes. This exclusion does not apply to the following:

1. Services which we are required by law to cover; 2. Services specified as covered in this booklet; 3. Dental services to prepare the mouth for radiation therapy to treat head and/or neck cancer.

Hearing Aids or Tests. Hearing aids and routine hearing tests, except as specified as covered in the EOC.

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.

In-vitro Fertilization. Services or supplies for in-vitro fertilization (IVF) for purposes of pre-implant genetic diagnosis (PGD) of embryos, regardless of whether they are provided in connection with infertility treatment. **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).

Gene Therapy. Gene therapy as well as any drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.

Foot Orthotics. Foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes. **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.

Education or Counseling. Educational services or nutritional counseling, except as specified as covered in the EOC. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa. Additionally, this exclusion does not apply to the *medically necessary* services to treat *severe mental disorders* 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. This exclusion does not apply to the *medically necessary* services to treat *severe mental disorders* or serious emotional disturbances of a child as required by state law. **Telephone and Facsimile Machine Consultations.** Consultations provided by telephone or facsimile machine. This exclusion does not apply to the *medically necessary* services to treat *severe mental disorders* or serious emotional disturbances of a child as required by state law.

Routine Physicals and Immunizations. Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law as specified 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 EOC. Any non-prescription, over-the-counter patent or proprietary drug or medicine. Cosmetics, health or beauty aids.

Drugs Given to you by a Medical Provider. The following exclusions apply to drugs you receive from a medical provider: ○ Delivery Charges. Charges for the delivery of prescription drugs. ○ 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 physician believes you need to use a different prescription drug, please have your physician 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.

- ○ Drugs Contrary to Approved Medical and Professional Standards. Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- ○ Drugs Over Quantity or Age Limits. Drugs which are over any quantity or age limits set by the plan or us.
- ○ Drugs Over the Quantity Prescribed or Refills After One Year. Drugs in amounts over the quantity prescribed or for any refill given more than one year after the date of the original prescription. ○ Drugs Prescribed by Providers Lacking Qualifications, Registrations and/or Certifications. Prescription drugs prescribed by a provider that does not have the necessary qualifications, registrations and/or certifications as determined by us.
- ○ Drugs That Do Not Need a Prescription. Drugs that do not need a prescription by federal law (including drugs that need a prescription by state law, but not by federal law), except for injectable insulin. This exclusion does not apply to over-the-counter drugs that we must cover under state law, or federal law when recommended by the U.S. Preventive Services Task Force, and prescribed by a physician.
- ○ Lost or Stolen Drugs. Refills of lost or stolen drugs.

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.

Medical Equipment, Devices and Supplies. This plan does not cover the following:

- Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
- Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
- Enhancements to standard equipment and devices that is not medically necessary.
- Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is medically necessary in your situation.

This exclusion does not apply to the medically necessary treatment as specifically stated as covered in the EOC/Certificate.

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

Private Duty Nursing. Private duty nursing services.

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 does not apply to the *medically necessary* services to treat *severe mental disorders* 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. This exclusion will not apply to cardiac rehabilitation programs approved by us. **Varicose Vein Treatment.** Treatment of varicose veins or

telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes. **Wigs.**

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.