Your Summary of Benefits
HMO Plans

Anthem Blue Cross

Small Group HMO $25 100%

Effective 10/2011

This Summary of Benefits is a brief overview of your plan's benefits only. 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.

Anthem Blue Cross HMO benefits are covered only when services are performed, prescribed, directed or authorized as medically necessary by a physician in the medical group the member has selected, except as stated in the Combined Evidence of Coverage and Disclosure Form (EOC) for a medical emergency including out of area urgently needed services. The procedures you follow to obtain care depend on the type of care you need. Except for obstetrical/gynecological care, emergency care and care for mental or nervous disorders and substance abuse, your Primary Care Physician or Medical Group is responsible for authorizing all the care you receive. If you are ever in doubt, contact them or your HMO Coordinator.

Many medical groups participate in the SpeedyReferral and DirectAccess Programs. SpeedyReferral makes the referral process faster and easier. DirectAccess allows you to self-refer to participating doctors who specialize in allergy, dermatology, and ear/nose/throat health conditions. Before contacting a specialist directly, confirm that your medical group participates in these programs.

Annual Out-of-Pocket Maximum: Individual $2,000; Family $4,000 (two or more members-aggregate)[f]

The following copays do not apply to the annual out-of-pocket maximum: Infertility services; prescription drug copays, pharmacy deductible; copay for not obtaining pre-service review; and costs for non-covered services.

Covered Services	Per Member Copay
Preventive Care 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 and HIV testing *This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.	No charge
Physician Medical Services • Office visits • Specialists • Skilled nursing facility visits • Hospital visits • Medications in physician's office *(excluding allergy serum and immunization)* • Surgeon & Surgical assistant • Anesthesiologist or anesthetist	 $25 copay/visit $35 copay/visit No charge No charge 30% up to $150 maximum copay No charge No charge
Outpatient Medical Services *(services received in a hospital, other than emergency room services, or in any facility that is affiliated with a hospital)* • Outpatient surgery & supplies • Advanced Imaging and sleep studies • All other X-ray & laboratory tests *(including genetic testing)* • Radiation therapy, chemotherapy & hemodialysis treatment & Infusion therapy • Other Outpatient Medical Services including: Rehabilitation Therapy *(Physical, Occupational, or Speech Therapy, limited to a 60-day period of care)*	 No charge $100 copay/test No charge $35 copay/visit $35 copay/visit
General Medical Services *(when performed in non-hospital-based facility)* • Advanced Imaging • All other X-ray & laboratory tests *(including genetic testing)* • Allergy testing & treatment *(including serums)* • Radiation therapy, chemotherapy & hemodialysis treatment & Infusion therapy • Rehabilitation Therapy *(Physical, Occupational, or Speech Therapy or Chiropractic Care, limited to 60-days period of care)*	 $100 copay/test No charge $25 copay/visit $35 copay/visit $25 copay/visit
Urgent Care	

CONTINUED ON NEXT PAGE

Covered Services	Per Member Copay
• Physician's office • Outpatient facility	$25 copay/visit $35 copay/visit
Emergency Care • Physician & medical services • Outpatient hospital emergency room services	No charge $150 copay/visit *(waived if admitted inpatient)*
Inpatient Medical Services • Semi-private room or private room if medically necessary; meals & special diets; services & supplies	No charge
Skilled Nursing Facility *(limited to 100 days/calendar year)* • All necessary services & supplies *(excluding take-home drugs)*	No charge
Ambulance Services • Ground or air ambulance transportation in a medical emergency or when ordered by the primary care physician, including medical services & supplies	$50/trip
Ambulatory Surgical Center • Outpatient surgery & supplies	No charge
Pregnancy and Maternity Care • Prenatal & postnatal Professional *(physician)* services *(For your Inpatient copay, see Inpatient Medical Services. For your Outpatient Services copay, see Outpatient Medical Services)* **Elective Abortions** *(including prescription drug for abortion, mifepristone)*	$25 copay/visit $150 copay/procedure
Family Planning Services • Infertility studies & tests. *(Maximum lifetime Anthem Blue Cross payment of $2,000)*	50% ‡
Mental or Nervous Disorders § • Outpatient mental health consultation *(limited to one visit/day and 20 visits/calendar year; pre-service review required after the 12th visit)* **Substance Abuse** • Inpatient detoxification for alcohol or drug abuse *(acute stage only; pre-service review required)*	$35 copay/visit No charge
Other Medical Services • Prosthetic devices • Durable Medical Equipment	No charge 50%
Home Health Care • Home visits when ordered by primary care physician *(limited to three two-hour visits/day)*	$25 copay/visit
Prescription Drugs (*outpatient prescriptions only*) 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 800-700-2533. • Calendar Year Pharmacy Deductible†† • Infertility Drug Lifetime Maximum	**Per Member Copay for Each Prescription or Refill** $150/member $1,500/member
Retail Participating Pharmacy *(30-day supply)*ǂ • Preventive Immunizations administered by a retail pharmacy • Tier 1 • Tier 2 *(includes diabetic supplies)* §§ • Tier 3 *(includes compound drugs)* §§	No charge *(deductible waived)* $10 copay *(deductible waived)* $30 copay $50 copay
Mail Service *(90-day supply)*ǂ • Tier 1 • Tier 2 *(includes diabetic supplies)* §§ • Tier 3‡‡	$10 copay *(deductible waived)* $60 copay $100 copay
Specialty Pharmacy Drugs *(may only be obtained through the specialty pharmacy program)* • Tier 4 drugs	30% of prescription drug maximum allowed amount up to a maximum $150 copay per fill

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).

The Prescription Drug Benefit covers the following:

- Preventive flu and pneumonia vaccines administered by a retail pharmacy.
- Outpatient Drugs and medications which federal and/or state of California law restrict to sale by Prescription only
- Insulin. Insulin syringes prescribed and dispensed for use with Insulin. Lancets and test strips for use in monitoring diabetes.
- Non-infused compound Prescriptions which may be limited to distribution at designated Participating pharmacies.
- Oral contraceptive Drugs prescribed for birth control. If your Physician determines that oral contraceptive Drugs are not medically appropriate, coverage for another FDA approved Prescription contraceptive method will be provided.
- Drugs and medications prescribed for the treatment of Infertility limited to a lifetime maximum payment of $1,500 per member. If such medications are classified as Specialty Drugs, they may be subject to the Specialty Pharmacy Program.
- Drugs and medications prescribed for the treatment of impotence and/or sexual dysfunction must be authorized in advance by Anthem Blue Cross and are limited to 8 tablets/units per 30 day period. (Not covered under the mail service prescription drug program.)
- Phenylketonuria (PKU) formulas and special food products to treat PKU that are listed on the Formulary and obtained from a pharmacy.
- Classified specialty drugs must be obtained through the mail order Specialty Pharmacy Program and are subject to the terms of the program. Limited to a 30-day supply.

Prescription drug copays are separate from the medical copays of the medical plan and are not applied toward the Annual Out-of-Pocket Maximums.

† Supply limits for certain drugs may be different. Please refer to the Certificate of Insurance or EOC for complete information.

‡ The member's percentage copay is not applicable to the annual out-of-pocket maximum.

§ Does not apply to coverage of severe mental illness and serious emotional disturbances of a child, except pre-service review.

f Per family amount is aggregate, i.e., when one or more family member's eligible covered expenses (combined) meet this amount, the requirement is satisfied for all covered family members.

†† Members are responsible to pay the prescription drug maximum allowed amount until the pharmacy deductible is met unless deductible is specifically waived. Once the pharmacy deductible is met, members are responsible for the copay amount.

‡‡ Compound drugs are not covered through mail service; only covered through certain retail participating pharmacies.

§§ If a member selects a brand name drug when a generic drug substitution exists, even if the member's physician has specified "dispense as written" (DAW) or "do not substitute", the member will be responsible for tier 1 copay, plus the difference between the cost of the generic drug and the cost of the brand name drug. The amount does not apply to the member's pharmacy deductible.

HMO Exclusions & Limitations

Prescription Drug Exclusions and Limitations

Any expense incurred in excess of the prescription drug maximum allowed amount at a Non-Participating Pharmacy

Drugs and medications which may be obtained without a Physician's Prescription, except Insulin and Niacin for cholesterol lowering

Prescription Drugs which have non-Prescription (over-the-counter) chemical and dosage equivalents. If a Drug is prescribed because the non-Prescription equivalent was tried and did not work, this exclusion does not apply

Non-medicinal substances or items

Over-the-counter smoking cessation drugs. This does not apply to Medically Necessary Drugs that you can only get with a prescription under state and federal law

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

Drugs and medications used to induce non-spontaneous abortions

Dietary supplements, herbs, vitamins, cosmetics, health or beauty aids, or similar products which are not FDA approved to diagnose, treat, cure or prevent a medical condition except for treatment of phenylketonuria

Drugs furnished by a Hospital, Skilled Nursing Facility, rest home, sanitarium, convalescent hospital or similar facility

Any Drug labeled "Caution, limited by federal law to investigational use", non-FDA approved Investigational drugs or any drug or medication prescribed for Experimental indications

Syringes and/or needles, except those dispensed for use with Insulin

Durable medical equipment, devices, appliances, and supplies

Immunizing agents, biological sera, blood, blood products or blood plasma

Oxygen

Professional charges in connection with administering, injecting or dispensing Drugs

Drugs and medications dispensed or administered in an outpatient setting, including, but not limited to, outpatient Hospital facilities and doctors' offices. Drugs prescribed for cosmetic purposes

Drugs prescribed for the primary purpose of treating Infertility in excess of the lifetime maximum

Drugs used for weight loss, except for the Medically Necessary treatment of morbid obesity

Drugs obtained outside the United States unless related to a Medical Emergency

Allergy desensitization products, allergy serum

All Infusion Therapy, except self-administered injectables and aerosols

Treatment of impotence and/or sexual dysfunction except as specified as covered in the EOC

Replacement of Drugs and medications when lost, stolen or damaged. Hepatitis B and varicella zoster (chicken pox) vaccines and childhood immunizations

A prescription dispensed in excess of 30-day supply (unless ordered by mail through the mail service prescription drug program, in which case the limit is 90-day supply)

Compound medications obtained from other than a participating pharmacy

Classified specialty drugs that must be obtained from the Specialty Pharmacy Program, but which are instead obtained from a retail pharmacy

Medical Plan Benefits Exclusions and Limitations - Following is an abbreviated list of exclusions and limitations; please see the Combined Evidence of Coverage and Disclosure Form for comprehensive details

Any amounts in excess of maximums stated in the Combined Evidence of Coverage and Disclosure Form Services or supplies that are not medically necessary

Services received before your effective date

Services received after your coverage ends

Any conditions for which benefits can be recovered under any workers' compensation law or similar law

Services you receive for which you are not legally obligated to pay

Services for which no charge is made to you in the absence of insurance coverage

Services not listed as covered in the Combined Evidence of Coverage and Disclosure Form

Services from relatives

Vision care except as specifically stated in the Combined Evidence of Coverage and Disclosure Form

Eye surgery performed solely for the purpose of correcting refractive defects

Hearing aids. Routine hearing tests, except as specifically stated in the Combined Evidence of Coverage and Disclosure Form Sex changes

Dental and orthodontic services except as specifically stated in the Combined Evidence of Coverage and Disclosure Form

Cosmetic surgery

Routine physical examinations except as specifically stated in the Combined Evidence of Coverage and Disclosure Form

Treatment of mental or nervous disorders (including nicotine use) or psychological testing, except as specifically stated in the Combined Evidence of Coverage and Disclosure Form

Custodial care

Experimental or investigational services

Services provided by a local, state or federal government agency, unless you have to pay for them

Diagnostic admissions

Telephone or facsimile machine consultations Commercial weight loss programs

Medical supplies and equipment/durable medical equipment, except as specifically stated in the Combined Evidence of Coverage and Disclosure Form

Specialty drugs, except as specifically stated in the Combined Evidence of Coverage and Disclosure Form Personal comfort items Health club memberships

Any services to the extent you are entitled to receive Medicare benefits for those services without payment of additional premium for Medicare coverage

Food or dietary supplements, except as specifically stated in the Combined Evidence of Coverage and Disclosure Form or as required by law

Genetic testing for nonmedical reasons or when there is no medical indication or no family history of genetic abnormality

Outdoor treatment programs

Replacement of prosthetics and durable medical equipment when lost or stolen

Any services or supplies provided in connection with a surrogate pregnancy

Immunizations solely for travel outside the United States

Educational services except as specifically stated in the Combined Evidence of Coverage and Disclosure Form

Infertility services (including sterilization reversal) except as specifically stated in the Combined Evidence of Coverage and Disclosure Form

Care provided in a noncontracting hospital

Private duty nursing

Services primarily for weight reduction except medically necessary treatment of morbid obesity

Outpatient drugs, medications or other substances dispensed or administered in any outpatient setting

Contraceptive devices unless your physician determines that oral contraceptive drugs are not medically appropriate

Care not authorized by your PMG or IPA

Amounts in excess of customary and reasonable charges for non-emergency care rendered by a nonparticipating provider without an authorized referral from your PMG or IPA

Rehabilitative care, such as physical therapy, occupational therapy, speech therapy, and chiropractic services except as specifically stated in the Combined Evidence of Coverage and Disclosure Form

Conditions of the jaw or teeth secondary to malocclusion or orthognathic conditions

Growth hormone treatment

Acupuncture/acupressure

Vein Treatment when services are rendered for cosmetic purposes

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, dental, prescription drug or vision coverage so that the services received from all group coverages do not exceed 100% of the covered expense

Effective 10/2011 Printed 09/2011 MCASB3978C 2011-10