Your Summary of Benefits
PPO Copay Plans

Small Group PPO 1000/$25

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.

In addition to dollar and percentage copays, members are responsible for deductibles, as described below, 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 certificate or EOC.

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. Non-participating hospitals are covered at a reduced benefit but there are no benefits for care in non-contracting hospitals, except for medical emergencies. 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.

Calendar year deductible for all providers (*Deductible must be met before covered amounts apply, except when deductible is waived*)	$1,000/member; two-member family maximum
Additional copayment for non-PPO providers if pre-service review not obtained *(waived in a medical emergency)*	$250/admission, treatment or therapy for hospital admissions, facility-based treatment admission of mental or nervous disorders and substance abuse, skilled nursing facility, infusion therapy, home health care, advanced imaging, certain surgical procedures
Additional copayment for emergency room services	$150/visit ***(waived if admitted directly from ER)***

Annual Out-of-Pocket Maximums *(PPO and non-PPO out-of-pocket maximums are exclusive of each other; includes calendar year deductible)*

• PPO Providers & Other Health Care Providers	$5,000/member; two-member family maximum
• Non-PPO Providers	Once Anthem Blue Cross payments reach $10,000 per member, member pays nothing for covered expenses for the remainder of the year, except as described below

The following do not apply to out-of-pocket maximums: pharmacy deductible (if applicable) and pharmacy copays; copays for acupuncture/acupressure; copay for mental or nervous disorders and substance abuse (except for treatment of severe mental illness and serious emotional disturbances of a child); copays for not obtaining pre-service review; $500 copay for infertility services; and non-covered expense. After a member reaches the out-of-pocket maximum during a calendar year, the member will no longer be required to pay a copay for the remainder of that year, except as stated in the Certificate or EOC. The member remains responsible for any charges in excess of covered expense.

Lifetime Maximum	Unlimited

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[ff]
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 copay ***(deductible waived)***	50%
• HealthyCheck[SM] Screenings ***(where available):*** Certain lab tests, immunizations and health education information	No copay ***(deductible waived)***	Not applicable
Physician Medical Services		
• Office visits ***(includes retail health clinic & online clinic visit)*** †	$25/visit ***(deductible waived)***	50%
• Hospital & skilled nursing facility visits	30%	50%

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Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[ff]
• Surgeon & surgical assistant; anesthesiologist or anesthetist	30%	50%
Physical Therapy, Occupational Therapy & Chiropractic Services (*limited to combined 24 visits/calendar year; additional visits may be authorized*)	30%	50% ***(benefit limited to $25/visit)***
Acupuncture/Acupressure • Services for the treatment of disease, illness or injury (***limited to $30/visit & 24 visits/calendar year***)	30%	50%
Diagnostic X-ray & Lab	30%	50%
Advanced Imaging *(pre-service review required)*	30%	50% ***(benefit limited to $800/procedure)***
Urgent Care *(physician services)* †	$25/visit ***(deductible waived)***	50%
Emergency Care • Emergency room services & supplies (***$150 copayment waived if admitted***) • Physician services	30% 30%	30% 30%
Hospital Medical Services *(pre-service review required for inpatient and certain outpatient services; waived for emergency admissions)* • Semi-private room, meals & special diets, & ancillary services • Outpatient medical care, surgical services & supplies (***hospital care other than emergency room care***)	30% 30%	50% ***(benefit limited to $650/day)*** 50% ***(benefit limited to $380/admit)***
Skilled Nursing Facility (*pre-service review required*) • Semi-private room, services & supplies (***limited to 100 days/ calendar year***)	30%	50% ***(benefit limited to $150/day)***
Ambulance • Ground or air ambulance transportation, services & disposable supplies ***(air ambulance in a non-medical emergency is subject to utilization review)***	30%	In an emergency or with an authorized referral: 30% Non-emergency or no referral: 50%
Ambulatory Surgical Centers *(pre-service review required for certain surgeries)* • Outpatient surgery, services & supplies	30%	50% ***(benefit limited to $380/admit)***

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Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[ff]
Pregnancy & Maternity Care • Physician office visits Normal delivery, cesarean section, complications of pregnancy & abortion ***(newborn routine nursery care covered when natural mother is member employee or spouse/domestic partner).*** **Refer to the Physician & Hospital Medical Services benefits for both inpatient and outpatient hospital coverage.**	$25/visit plus 30% for all other covered services	50%
Infertility Services[f] (***limited to $2,000/lifetime***)	$500 plus 30% of balance	$500 plus 50% of balance
Mental or Nervous Disorders and Substance Abuse[§] • Facility-based care (***pre-service review required; limited to 30 days per year, in and out of network combined***) • Professional services (***One visit per day, 20 visits per year, in network and out of network combined; pre-service review required after the 12th visit***)	30% 30%	50% ***(benefit limited to $175/day)*** 50% ***(benefit limited to $25/visit)***
Durable Medical Equipment *(pre-service review may be required)*	50%	50%
Home Health Care (*pre-service review required*) • Services & supplies from a home health agency (***limited to 100 four-hour visits/calendar year***)	30%	50% ***(benefit limited to $75/visit)***
Infusion Therapy (*pre-service review required*)[f] • Includes chemotherapy	30%	50% ***(benefit limited to $50/day for expenses except drugs; all charges over wholesale cost of infusion therapy drugs; combined limit $500/day)***
Prescription Drugs 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	$250/member [‡‡] $1,500/member	
Retail Participating Pharmacy *(30-day supply)* [‡] • Preventive Immunizations administered by a retail pharmacy • Tier 1 • Tier 2 ***(includes diabetic supplies)*** • Tier 3 ***(includes compound drugs)***	No copay ***(deductible waived)*** $10 ***(deductible waived)*** $30 [††] $50 [††]	
Mail Service *(90-day supply)* [‡] • Tier 1 • Tier 2 ***(includes diabetic supplies)***	$10 ***(deductible waived)*** $60 [††]	

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Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[ff]
○ Tier 3 [§§]	$100 [††]	
Specialty Pharmacy Drugs *(may only be obtained through the specialty pharmacy program)*		
○ Tier 4	30% of prescription drug maximum allowed amount up to a maximum $150 copay per fill	
○ Tier 4 Out of Pocket Maximum Tier 4 prescription drug copayments will accrue to a maximum of $3,500 per member per year. Once the member has satisfied the $3,500 maximum, no additional copayments will be required for the remainder of the year for Tier 4 prescription drugs.		
Non-participating Pharmacies (30-day supply)[‡]		
○ In California	50% of the prescription drug maximum allowed amount plus excess charges	
○ Outside California	Copay above plus all charges in excess of prescription drug maximum allowed amount	

Additional information about your outpatient prescription drug benefits:

- 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 contain at least one covered prescription ingredient 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 specialty pharmacy program and are subject to the terms of the program.

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

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 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.

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

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

f Classified specialty drugs must be obtained through our Specialty Pharmacy Program and are subject to the terms of the program.

†† 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 generic copay, plus the difference between the cost of the generic drug and the cost of the brand name drug.

‡‡ 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.

ff Member pays copay plus all charges in excess of the maximum allowed amount.

PPO Exclusions & Limitations

Following is an abbreviated list of exclusions and limitations; please see the Certificate of Insurance (Certificate) or Combined Evidence of Coverage and Disclosure Form (EOC) for comprehensive details.

Prescription Drug Exclusions & Limitations

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. Any expense for a drug or medication incurred in excess of (a) the prescription drug maximum allowed amount for drugs dispensed by non-participating pharmacies; or (b) the outpatient prescription drug maximum allowed amount for drugs dispensed by participating pharmacies or through the mail service program.

Pharmaceuticals to aid smoking cessation (e.g., Nicorette or nicotine patches), over the counter remedies, or any Prescription product containing nicotine except as specified as covered in the Certificate or EOC.

Contraceptive devices prescribed for birth control except as specified as covered in the Certificate or 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, except lancets and test strips for use in monitoring diabetes.

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 when used for cosmetic purposes.

Drugs when used 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.

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 Certificate or EOC.

Replacement of Drugs and medications when lost, stolen or damaged.

A prescription dispensed in excess of a 30-day supply (unless ordered by mail through the mail service 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 through our Specialty Pharmacy Program and are instead obtained from a retail pharmacy.

Medical Exclusions & Limitations

Any amounts in excess of maximums stated in the certificate or EOC

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 certificate or EOC

Services from relatives

Vision care except as specifically stated in the certificate or EOC

Eye surgery performed solely for the purpose of correcting refractive defects

Hearing aids.

Routine hearing tests except as specifically stated in the certificate or EOC

Sex changes

Dental and orthodontic services except as specifically stated in the certificate or EOC

Cosmetic surgery

Routine physical examinations except as specifically stated in the certificate or EOC

Treatment of mental or nervous disorders and substance abuse (including nicotine use) or psychological testing, except as specifically stated in the certificate or EOC

Custodial care

Experimental or investigational services

Commercial weight loss programs

Medical supplies and equipment/durable medical equipment, except as specifically stated in the certificate or EOC

Specialty drugs, except as specifically stated in the certificate or EOC

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

Diagnostic admissions

Telephone or facsimile machine consultations

Personal comfort items

Nutritional counseling

Online Clinic Visits except as specifically covered in the Certificate or EOC. ÂÂ

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 certificate or EOC 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 to any person not covered under the Agreement in connection with a surrogate pregnancy

Immunizations solely for travel outside the United States

Services or supplies related to a pre-existing condition

Educational services except as specifically provided or arranged by Anthem Blue Cross

Infertility services (including sterilization reversal and costs associated with the storage of sperm, eggs, embryos and ovarian tissue) except as specifically stated in the certificate or EOC

Care or treatment provided in a noncontracting hospital

Private duty nursing except as specifically stated in the certificate or EOC

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.

Vein Treatment: Treatment of varicose veins or telangiectatic dermal veins (spider veins) by anyÂÂ method (including sclerotherapy or other surgeries) 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.

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