Custom Premier HMO 20

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 proposed benefit summary is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care.

Anthem Blue Cross HMO benefits are covered only when services are provided or coordinated by the primary care physician and authorized by the participating medical group or independent practice association (IPA), except services provided under the "ReadyAccess" program, OB/GYN services received within the member's medical group/IPA, and services for all mental and nervous disorders and substance abuse. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Annual copay maximum: Individual $500; Family $1,500

The following copay does not apply to the annual copay maximum: for infertility services. After an annual copay maximum is met for medical and prescription drugs during a calendar year, the individual member or family will no longer be required to pay a copay or coinsurance for medical and prescription drug covered expenses for the remainder of that year. The member remains responsible for non-covered expenses infertility services.

Covered Services	Per Member Copay
Inpatient Medical Services	
➢ Semi-private room or private room if medically necessary; meals & special diets; services & supplies including: — Special care units — Operating room & special treatment rooms — Nursing care — Drugs, medications & oxygen administered in the hospital	No copay
➢ Blood & blood products	No copay
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	No copay
➢ Diagnostic X-ray & laboratory procedures	
— CT or CAT scan, MRI or nuclear cardiac scan	$100/test
— PET scan	$100/test
— All other X-ray & laboratory tests *(including mammograms and ultrasounds)*	No copay
➢ Radiation therapy, chemotherapy & hemodialysis treatment & Infusion therapy	No copay
➢ Short-term Physical, Occupational, or Speech Therapy *(limited to a 60-day period of care after an illness or injury; additional visits available when approved by the medical group)*	No copay
Ambulatory Surgical Center	
➢ Outpatient surgery & supplies	No copay
Skilled Nursing Facility *(limited to 100 days/calendar year; limit does not apply to mental health and substance abuse)*	
➢ All necessary services & supplies *(excluding take-home drugs)*	No copay
Hospice Care *(Inpatient or outpatient services for members; family bereavement services)*	No copay
Home Health Care	
➢ Home visits when ordered by primary care physician *(limited to three 2-hour visits per day)*	$20/Visit
Physician Medical Services	
➢ Office & home visits *(includes retail health clinic)*	$20/visit
➢ Preferred Online visits (LiveHealth Online) *(includes Mental/Behavioral Health and Substance Abuse)*	$20/visit
➢ Hospital visits	No copay
➢ Skilled nursing facility visits	No copay
➢ Specialists & consultants	$20/visit

Covered Services	Per Member Copay
Short-Term Physical, Occupational, or Speech Therapy, or Chiropractic Care when Ordered by the Primary Care Physician *(limited to a 60-day period of care after an illness or injury; additional visits available when approved by the medical group)*	$20/visit
Acupuncture	$20/visit
Surgical Services	
➢ Surgeon & surgical assistant	No copay
➢ Anesthesiologist or anesthetist	No copay
General Medical Services *(when performed in non-hospital-based facility)*	
➢ Diagnostic X-ray & laboratory procedures	
— CT or CAT scan, MRI or nuclear cardiac scan	$100/test
— PET scan	$100/test
— All other X-ray & laboratory tests *(including mammograms, pap smears, & prostate cancer screening)*	No copay
➢ Radiation therapy, chemotherapy & hemodialysis treatment	No copay
Other Medical Services	
➢ Prosthetic devices	No copay
➢ Durable medical equipment including hearing aids *(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)*	20% of charges
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
Health Education and Wellness Programs	
➢ Specified immunizations	No copay
➢ Allergy testing & treatment *(including serums)*	$20/exam
➢ Medical social services	No copay
➢ Selected health education programs	No copay
Emergency Care **In Area** *(within 20 miles of medical group)* **and Out of Area**	
➢ Physician & medical services	No copay
➢ Outpatient hospital emergency room services	$100/visit *(waived if admitted)*
➢ Inpatient hospital services	No copay
Ambulance Services	
➢ Ground or air ambulance transportation when medically necessary, including medical services & supplies	No copay

Covered Services	Per Member Copay
Pregnancy and Maternity Care	
Office Visits	
➢ Prenatal & postnatal care	$20/visit
➢ Complications of pregnancy or abortions	$20/visit
Normal Delivery or Cesarean Section, including:	
➢ Inpatient hospital & ancillary services	No copay
➢ Routine nursery care	No copay
➢ Physician services *(inpatient only)*	No copay
Complication of Pregnancy or Abortion, including:	
➢ Inpatient hospital & ancillary services	No copay
➢ Outpatient hospital services	No copay
➢ Physician services *(inpatient only)*	No copay
Abortions *(including prescription drug for abortion [mifepristone])*	No copay
Genetic Testing of Fetus	No copay
Family Planning Services	
➢ Infertility studies & tests	50% of covered expense[1]
➢ Female Sterilization *(including tubal ligation and counseling/consultation*)	No copay
➢ Male Sterilization	$50
➢ Counseling & consultation	No copay
Organ and Tissue Transplant	
➢ Inpatient Care	No copay
➢ Physician office visits *(including primary care, specialty care & consultants)*	$20/visit
Mental/Behavioral Health and Substance Abuse	
➢ Inpatient facility care *(subject to utilization review; waived for emergency admissions)*	No copay
➢ Inpatient physician visits	No copay
➢ Outpatient facility care	No copay
➢ Physician office visits	No copay
Smoking Cessation Program	No copay

[1] Not applicable to the annual copay maximum

This Summary of Benefits is a brief review of benefits. Once enrolled, members will receive the 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.

Premier HMO — Exclusions and Limitations

Care Not Approved. Care from a health care provider without the OK of primary care doctor, except for emergency services or urgent care.

Care Not Covered. Services before the member was on the plan, or after coverage ended.

Care Not Listed. Services not listed as being covered by this plan.

Care Not Needed. Any services or supplies that are not medically necessary.

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 **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 ask that the denial be reviewed by an external independent medical review organization, as described in the Evidence of Coverage (EOC).

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.

Government Treatment. Any services the member actually received that were given by a local, state or federal government agency, except when this plan's benefits, must be provided by 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 Received Outside of the United States. Services rendered by providers located outside the United States, unless the services are for an emergency, emergency ambulance or urgent care**.**

Services Not Needing Payment. Services the member is **not** required to pay for or are given to the member at no charge, except services the member got at a charitable research hospital (not with the government). This hospital must:

1. Be known throughout the world as devoted to medical research.
2. Have at least 10% of its yearly budget spent on research not directly related to patient care.
3. Have 1/3 of its income from donations or grants (not gifts or payments for patient care).
4. Accept patients who are not able to pay.
5. Serve patients with conditions directly related to the hospital's research (at least 2/3 of their patients).

Work-Related. Care for health problems that are work-related if such health problems are or can be covered by workers' compensation, an employer's liability law, or a similar law. We will provide care for a work-related health problem, but, we have the right to be paid back for that care. See "Third Party Liability" below.

Acupressure. Acupressure, or massage to help pain, treat illness or promote health by putting pressure to one or more areas of the body.

Air Conditioners. Air purifiers, air conditioners, or humidifiers.

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.

Blood. Benefits are not provided for the collection, processing and storage of self-donated blood unless it is specifically collected for a planned and covered surgical procedure.

Braces or Other Appliances or Services for straightening the teeth (orthodontic services).

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.

Consultations given by telephone or fax. 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.

Weight loss. Services, programs, or supplies for losing weight or the treatment of obesity. We will cover this kind of care if we find that the member is morbidly obese.
Cosmetic Surgery. Surgery or other services done only to make the member: look beautiful; to improve appearance; or to change or reshape normal parts or tissues of the body. This does not apply to reconstructive surgery the member might need to: get back the use of a body part; have for breast reconstruction after a mastectomy; correct or repair a deformity caused by birth defects, abnormal development, injury or illness in order to improve function, symptomatology or create a normal appearance. Cosmetic surgery does not become reconstructive because of psychological or psychiatric reasons.

Custodial Care or Rest Cures. Room and board charges for a hospital stay mostly for a change of scene or to make **the member** feel good. Services given by a rest home, a home for the aged, or any place like that.

Dental Services or Supplies. Dentures, bridges, crowns, caps, or dental prostheses, dental implants, dental services, tooth extraction, or treatment to the teeth or gums. Cosmetic dental surgery or other dental services for beauty purposes.

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

Drugs Given to you by a Doctor. The following exclusions apply to drugs you receive from a doctor:

• 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 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.

• Compound Drugs. Compound drugs unless all of the ingredients are FDA-approved in the form in which they are used in the compound drug and as designated in the FDA's Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations, require a prescription to dispense, and the compound drug is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.

• 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 doctor.

• Lost or Stolen Drugs. Refills of lost or stolen drugs.

• Non-Approved Drugs. Drugs not approved by the FDA.

Eye Exercises or Services and Supplies for Correcting Vision. Optometry services, eye exercises, and orthoptics, except for eye exams to find out if the member's vision needs to be corrected. Eyeglasses or contact lenses are not covered. Contact lens fitting is not covered.

Eye Surgery for Refractive Defects. Any eye surgery just for correcting vision (like nearsightedness and/or astigmatism). Contact lenses and eyeglasses needed after this surgery.

Nutrition. Food or nutritional supplements except for special food products and formulas that are part of a special diet prescribed by a doctor for the treatment of phenylketonuria. 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.

Exercise Equipment. Exercise equipment, or any charges for fitness programs. This includes charges like those from a physical fitness instructor, health club or gym, even if doctor advises the member to change one's lifestyle.

Hearing Aids. Hearing aids or exams to prescribe or fit hearing aids, including bone-anchored hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.

Immunizations. Immunizations needed to travel outside the USA.

Infertility Treatment. Any infertility treatment including artificial insemination or in vitro fertilization, sperm bank, and any related laboratory tests.

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.

Lifestyle Programs. Programs to help member change how one lives, like fitness clubs, or dieting programs. This does not apply to cardiac rehabilitation programs approved by the medical group.

Mental Health Conditions Academic or educational testing, counseling. Remedying an academic or education problem, except as stated as covered in the EOC.

Non-Prescription Drugs. Non-prescription, over-the-counter drugs or medicines.

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. **Outpatient Drugs.** Outpatient prescription drugs or medications including insulin.

Personal Care and Supplies. Services for personal care, such as: help in walking, bathing, dressing, feeding, or preparing food. Any supplies for comfort, hygiene or beauty purposes.

Personal Care, Convenience and Mobile/Wearable Devices.

• Items for personal comfort, convenience, protection, cleanliness or beautification such as air conditioners, humidifiers, air or water purifiers, sports helmets, raised toilet seats and shower chairs.

• First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads, disposable sheaths and supplies).

• Home workout or therapy equipment, including treadmills and home gyms.

• Pools, whirlpools, spas, or hydrotherapy equipment.

• Hypo-allergenic pillows, mattresses, or waterbeds.

• Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).

• Consumer wearable / personal mobile devices such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.

Medical Equipment, Devices and Supplies

• 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.

• Non-Medically Necessary enhancements to standard equipment and devices.

• Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is your responsibility.

• Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered in the "What's Covered" section.

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

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, infirmary, school infirmary, 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.

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. 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.**Scalp hair prostheses.** Scalp hair prostheses, including wigs or any form of hair replacement.

Sexual Problems. Treatment of any sexual problems unless due to a medical problem, physical defect, or disease.

Sterilization Reversal. Surgery done to reverse a sterilization.

Surrogate Mother Services. For any services or supplies provided to a person not covered under **Surrogacy.** Any services or supplies given for a surrogate pregnancy (i.e., the bearing of a child by another woman for an infertile couple), unless the member is the surrogate mother.

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.

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.

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.

Services Received from Providers on a Federal or State Exclusion List. Any service, drug, drug regimen, treatment, or supply furnished, ordered or prescribed by a provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies. This exclusion does not apply to an emergency medical condition.

Aids for Non-verbal Communication. Devices and computers to assist in communication and speech except for speech aid devices and tracheoesophageal voice devices approved by Anthem.

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 the Medically Necessary services to treat Severe Mental Illness or Serious Emotional Disturbances of a Child as required by state law.

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.

Gene Therapy. Gene therapy that introduces or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material. While not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, benefits may be available under the "Gene Therapy Services" benefit. Please see that section for details. **Autopsies**. Autopsies and post-mortem testing.

Dental Devices for Snoring. Oral appliances for snoring.

Hospital Services Billed Separately. Services rendered by Hospital resident Doctors or interns that are billed separately. This includes separately billed charges for services rendered by employees of Hospitals, labs or other institutions, and charges included in other duplicate billings.

Growth Hormone Treatment. Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.

Hyperhidrosis Treatment. Medical and surgical treatment of excessive sweating (hyperhidrosis).

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.