

Your Summary of Benefits Hospital Benefits Plans



Small Group Hospital Benefits Preferred Plan

Effective 2/2011

Note: This is a hospital only plan and provides limited benefits.

In addition to dollar and percentage copays, insureds are responsible for deductibles, as described below. Insureds are also responsible for all costs over the plan maximums. Plan maximums and other important information appear in italics.

Explanation of Covered Expense

Plan payments are based on covered expense, which is the lesser of the charges billed by the provider or the following:

PPO: PPO negotiated rates. Insureds are not responsible for the difference between the provider's usual charges & the negotiated amount.

Non-PPO: (includes those not represented in the PPO provider network): the allowed amount for professional services and institutional services. For Special Circumstances and Other Eligible Health Care Providers, including emergency care-the customary & reasonable charge (C&R) for professional services and institutional services. When using Non-PPO and Other Eligible Health Care Providers, insureds are responsible for any difference between the allowed amount & actual charges, as well as any deductible & percentage copay.

Calendar year deductible for all providers (*Deductible must be met before covered amounts apply, except for preventive care services, HealthyCheck screenings and prescription drugs.*) \$750/Insured; two-insured family maximum

Additional copayment for inpatient hospital, facility based treatment for mental or nervous disorders and substance abuse, ambulatory surgical center, skilled nursing facility, infusion therapy or home health care, if preservice review is not obtained \$250/admission, treatment or therapy (waived for emergency admission)

Additional copayment for emergency room services \$100/visit (waived if admitted directly from ER)

Annual Out-of-Pocket Maximums for all providers. In-network and out-of-network combined Deductible plus \$2,500/Insured/year; two-insured family maximum

The following do not apply to out-of-pocket maximums: annual deductible; copays for pharmacy benefits; copays for not obtaining pre-service review; and non-covered expense. After an insured reaches the out-of-pocket maximum during a calendar year, the insured will no longer be required to pay a copay for the remainder of that year, except as stated in the Certificate. The insured remains responsible for certain dollar copays; percentage copays; charges in excess of annual or lifetime maximums & costs in excess of the covered expense as stated in the Certificate.

Lifetime Maximum Unlimited

Covered Services	PPO: Per Insured Copay	Non-PPO: Per Insured Copay
Preventive Care^{†††} Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits <ul style="list-style-type: none"> Routine physical exams, immunizations, diagnostic x-ray & lab for routine physical exam Adult Preventive Services (<i>including mammograms, pap smears, prostate & colorectal cancer screenings</i>) HealthyCheckSM Screenings (<i>where available</i>): Certain lab tests, immunizations and health education information 	No copay <i>(deductible waived)</i> No copay <i>(deductible waived)</i> No copay <i>(deductible waived)</i>	50% ^{§§} 50% ^{§§} Not applicable
Physician Medical Services <ul style="list-style-type: none"> Office visits Hospital & skilled nursing facility visits Surgeon & surgical assistant; anesthesiologist or anesthesiologist 	50% <i>(deductible waived)</i> 30% 30%	50% ^{§§} <i>(deductible waived)</i> 50% ^{§§} 50% ^{§§}
Physical Therapy, Occupational Therapy & Chiropractic Services	Not covered	Not covered

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Covered Services	PPO: Per Insured Copay	Non-PPO: Per Insured Copay
Acupuncture/Acupressure <ul style="list-style-type: none"> Services for the treatment of disease, illness or injury (<i>limited to 24 visits/calendar year</i>) 	All of the negotiated fee except \$30/visit	All charges except \$30/visit
Diagnostic X-Ray & Lab <i>(pre-service required for certain diagnostic procedures)</i>	50% <i>(deductible waived)</i>	50% ^{ss} <i>(deductible waived)</i>
Emergency Care <ul style="list-style-type: none"> Emergency room services & supplies (<i>\$100 copayment waived if admitted</i>) Inpatient hospital services & supplies Physician services 	30% 30% 30%	30% of customary & reasonable (C&R) ^{††} 30% of (C&R) ^{††} 30% of (C&R) ^{††}
Hospital Medical Services <i>(pre-service review required)</i> <ul style="list-style-type: none"> Semi-private room, meals & special diets, & ancillary services Outpatient medical care, surgical services & supplies (<i>hospital care other than emergency room care</i>) 	30% 30%	All charges except \$650/day All charges in excess of \$380/day
Skilled Nursing Facility <i>(pre-service review required)</i> <ul style="list-style-type: none"> Semi-private room, services & supplies (<i>100 days per year, in-network and out-of-network combined</i>) 	30%	All charges in excess of \$150/day
Ambulance <ul style="list-style-type: none"> Ground or air ambulance transportation, services & disposable supplies (limited to \$750/trip) 	30%	50% ^{ss}
Ambulatory Surgical Centers <i>(pre-service review required)</i> <ul style="list-style-type: none"> Outpatient surgery, services & supplies 	30%	All charges except \$380/day
Pregnancy & Maternity Care <ul style="list-style-type: none"> Physician office visits <p>Normal delivery, cesarean section, complications of pregnancy & abortion (<i>newborn routine nursery care covered when natural mother is subscriber or spouse</i>)</p> <ul style="list-style-type: none"> Inpatient physician services Hospital & ancillary services 	50% of negotiated fee. Not subject to deductible. Limited professional services including maternity: 20% of negotiated fee after annual deductible. 30% 30%	50% ^{ss} of negotiated fee. Not subject to deductible. Limited professional services including maternity: 50% of negotiated fee plus 100% of excess charges after annual deductible. 50% ^{ss} All charges except \$650/day
Infertility Services <i>(limited to \$2,000/lifetime)</i> <ul style="list-style-type: none"> Inpatient hospital services & supplies Outpatient facility services & supplies Inpatient professional services 	30% 30% 30%	All charges except \$650/day All charges except \$380/day 50% ^{ss}
Mental or Nervous Disorders and Substance Abuse[‡] <ul style="list-style-type: none"> Facility-based care (<i>pre-service review required; limited to 30 days/calendar year, in and out of network combined</i>) Professional services 	30% ^{††} Not covered	50% ^{f ††} Not covered
Home Health Care <i>(pre-service review required)</i> <ul style="list-style-type: none"> Services & supplies from a home health agency (<i>100 four-hour visits per year, in-network and out-of-network combined</i>) 	30%	All charges in excess of \$75/visit

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Covered Services	PPO: Per Insured Copay	Non-PPO: Per Insured Copay
Infusion Therapy^s (pre-service review required) <ul style="list-style-type: none"> Includes chemotherapy 	30%	50% of negotiated fee plus charges in excess of \$50/day of expenses except drugs; all charges over wholesale cost of infusion therapy drugs; combined limit \$500/day
Prescription Drugs		
Participating Retail Pharmacy (30-day supply)[†] <ul style="list-style-type: none"> Generic drugs^{ff} Brand name drugs Generic self-administered injectable drugs, except insulin Non-participating Pharmacies (30-day supply)[†] <ul style="list-style-type: none"> In California^{ff} Outside of California^{ff} 	\$15 Not covered 30% of negotiated fee up to \$100 per fill	50% of the Drug limited fee schedule plus all charges in excess of the Drug limited fee schedule Copay above plus all charges in excess of Drug limited fee schedule
Mail Service (90-day supply)[†] <ul style="list-style-type: none"> Generic drugs^{ff} Brand name drugs 	\$15 Not covered	

The Prescription Drug Benefit covers the following generic drugs listed on the GenRx Formulary:

- Outpatient Generic 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.
- Oral contraceptive Generic 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.
- Generic Drugs and medications prescribed for the treatment of impotence and/or sexual dysfunction must be authorized in advance by Anthem Blue Cross Life and Health and are limited to 8 tablets/units per 30 day period. (Not covered under the mail service prescription drug program.)
- Generic Infertility drugs limited to \$1,500 lifetime maximum payment.

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 is a brief review of benefits. Once enrolled, insureds will receive a Certificate, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.

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).

- †** Supply limits for certain drugs may be different. Please refer to the Certificate of Insurance for complete information.
- ‡** Does not apply to coverage of severe mental illness and serious emotional disturbances of a child, except pre-service review.
- §** Classified specialty drugs must be obtained through our Specialty Pharmacy Program and are subject to the terms of the program.
- f** Plus all charges in excess of Negotiated Fee Rate.
- ††** Plus all charges in excess of Customary & Reasonable (C&R).
- ‡‡** Does not apply to Out-of-pocket Maximum. Please see the EOC or Certificate for complete information.
- §§** Plus all charges in excess of Negotiated Fee Rate for Non-PPO providers.
- ff** For generic drugs listed on the Generic Drug Formulary.
- †††** Age and frequency limitations may apply. When applicable, each family member ages 7 - adult may choose annually between the physical exam and the HealthyCheck screening.

Prescription Drug Exclusions & Limitations Prescription drugs not listed on the GenRx Formulary. Brand name drugs, except as listed on the GenRx Formulary. 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 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 Drug Limited Fee Schedule for drugs dispensed by non-participating pharmacies; or (b) the outpatient prescription drug negotiated rate 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. Contraceptive devices prescribed for birth control except as specified as covered in the Certificate. 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 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. 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).

Hospital Benefits PPO Plan - Exclusions and Limitations Following is an abbreviated list of exclusions and limitations; please see the Certificate for comprehensive details. Any amounts in excess of maximums stated in the Certificate. 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. Services from relatives. Vision care except as specifically stated in the Certificate. Eye surgery performed solely for the purpose of correcting refractive defects. Hearing aids. Routine hearing tests except as specifically stated in the Certificate. Sex changes. Dental and orthodontic services except as specifically stated in the Certificate. Cosmetic surgery. Routine physical examinations except as specifically stated in the Certificate. Treatment of mental or nervous disorders and substance abuse (including nicotine use) or psychological testing, except as specifically stated in the Certificate. 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. Personal comfort items. Nutritional counseling. Health club memberships. Commercial weight loss programs. Medical supplies and equipment/durable medical equipment, except as specifically stated in the Certificate. Specialty drugs, except as specifically stated in the Certificate. 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 as required by law. Genetic testing for non-medical 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) except as specifically stated in the Certificate. Care or treatment provided in a non-contracting hospital. Private duty nursing except as specifically stated in the Certificate. 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. **Third Party Liability** - Anthem Blue Cross Life and Health Insurance Company is entitled to reimbursement of benefits paid if the insured person recovers damages from a legally liable third party. **Coordination of Benefits** - The benefits of this plan may be reduced if the insured person 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.

In our efforts to better serve you, Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company now offer a Language Assistance Program to our members. Our language assistance program provides free oral interpretations in many languages, and free written translation assistance is available in Spanish, Chinese, Tagalog, Korean and Vietnamese for this and other health-related documents. If you need written translation assistance for health-related documents, call Customer Service toll free at 800-627-8797, and a language representative will assist you.

This information will not be used in determining eligibility or insurability.

Language Assistance Services

English

Can you read the attached document? If not, we can have somebody help you read it. You may also be able to get this written in your language. For free help, please call right away at 800-627-8797.

Spanish

Puede usted leer este documento anexo? Si no, podemos asignarle alguien que le ayude. También puede recibir esto escrito en su idioma. Para obtener ayuda gratuita, llame ahora mismo al 800-627-8797.

Chinese (Traditional)

您能讀懂所附文件嗎?如果無法閱讀,我們將為您提供專員協助服務。我們也能將此信翻譯成您所使用的語言。欲洽詢免費服務,請立即致電 800-627-8797。

Korean

첨부 서류를 읽으실 수 있습니까? 만일 어려움이 있다면 이서신을 잘 읽을 수 있도록 도움을 드릴 수 있습니다. 또한 여러분은 이 서신의 한국어 번역본을 제공받으실 수 있습니다. 이 무료 서비스를 원하시는 분은 지금바로 800-627-8797 로 전화하십시오.

Vietnamese

Quý vị đọc được tài liệu đính kèm không? Nếu không, chúng tôi có thể nhờ người giúp quý vị đọc thư. Quý vị cũng có thể nhận thư này bằng tiếng Việt. Để được giúp đỡ miễn phí, xin gọi ngay số 800-627-8797.

Tagalog

Kaya mo bang basahin ang nakakabit na dokumento? Kung hindi, makakakuha kami ng taong makakatulong sa inyo na basahin ito. Maaari ninyo ring makuha ang liham na ito sa inyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 800-627-8797.

If you have any questions regarding our language assistance program or need more information, contact 800-627-8797 or visit anthem.com/ca.

We hope this program will assist you in providing the language services you need.