

# Your Summary of Benefits Premier PPO



## Small Group Premier PPO \$30 Copay Plan

### Effective 2/2011

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.

### 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. Members 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 for professional services and institutional services. When using Non-PPO and Other Eligible Health Care Providers, members 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 office visits, preventive care services, HealthyCheck screenings and prescription drugs.*) \$500/member; two-member 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 pre-service review 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

- PPO Providers & Other Health Care Providers \$3,500/member/year; two-member family maximum
- Non-PPO Providers \$7,000/member/year; two-member family maximum

The following do not apply to out-of-pocket maximums: copays for pharmacy benefits; 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 in 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 Combined Evidence of Coverage and Disclosure Form. For non-PPO providers, the member remains responsible for any charges in excess of the covered expense. Copayments made to PPO providers will not apply to out of pocket maximums for non- PPO providers, and copayments made to non- PPO Providers will not apply to out-of-pocket maximums for PPO providers.

**Lifetime Maximum** Unlimited

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay
<b>Preventive Care<sup>SS</sup></b> <i>Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits</i> <ul style="list-style-type: none"> <li>• Routine physical exams, immunizations, diagnostic x-ray &amp; lab for routine physical exam</li> <li>• Adult Preventive Services (<i>including mammograms, pap smears, prostate &amp; colorectal cancer screenings</i>)</li> <li>• HealthyCheck<sup>SM</sup> Screenings (<i>where available</i>): Certain lab tests, immunizations and health education information</li> </ul>	No Copay <i>(deductible waived)</i>  No copay <i>(deductible waived)</i>  No copay <i>(deductible waived)</i>	50% <i>(deductible waived for office visit)</i> 50% <i>(deductible waived for office visit)</i> Not applicable
<b>Physician Medical Services</b> <ul style="list-style-type: none"> <li>• Office visits (<i>not subject to deductible</i>)</li> <li>• Hospital &amp; skilled nursing facility visits</li> </ul>	\$30/visit  30%	50% <sup>f</sup>  50% <sup>f</sup>

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay
<ul style="list-style-type: none"> <li>Surgeon &amp; surgical assistant; anesthesiologist or anesthesiologist</li> </ul>	30%	50% <sup>f</sup>
<b>Physical Therapy, Occupational Therapy &amp; Chiropractic Services</b> <i>(limited to combined 24 visits/calendar year; additional visits may be authorized)</i>	30%	All charges except \$25/visit
<b>Acupuncture/Acupressure</b>		
<ul style="list-style-type: none"> <li>Services for the treatment of disease, illness or injury <i>(limited to 24 visits/calendar year)</i></li> </ul>	30% <sup>††</sup>	All charges except \$30/visit <sup>††</sup>
<b>Diagnostic X-ray &amp; Lab</b> <i>(pre-service review required for certain diagnostic procedures)</i>	30%	50% <sup>f</sup>
<b>Emergency Care</b>		
<ul style="list-style-type: none"> <li>Emergency room services &amp; supplies <i>(\$100 copayment waived if admitted)</i></li> <li>Inpatient hospital or ambulatory surgical center services &amp; supplies</li> <li>Physician services</li> </ul>	30% 30% 30%	30% <sup>f</sup> 30% <sup>f</sup> 30% <sup>f</sup>
<b>Hospital Medical Services</b> <i>(pre-service review required)</i>		
<ul style="list-style-type: none"> <li>Semi-private room, meals &amp; special diets, &amp; ancillary services</li> <li>Outpatient medical care, surgical services &amp; supplies <i>(hospital care other than emergency room care)</i></li> </ul>	30% 30%	50% <sup>f</sup> 50% <sup>f</sup>
<b>Skilled Nursing Facility</b> <i>(pre-service review required)</i>		
<ul style="list-style-type: none"> <li>Semi-private room, services &amp; supplies <i>(limited to 100 days/calendar year)</i></li> </ul>	30%	All charges except \$150/day
<b>Ambulance</b>		
<ul style="list-style-type: none"> <li>Ground or air ambulance transportation, services &amp; disposable supplies</li> </ul>	30%	In an emergency or with an authorized referral: 30% <sup>f</sup> Non-emergency or no referral: 50% <sup>f</sup>
<b>Ambulatory Surgical Centers</b> <i>(pre-service review required)</i>		
<ul style="list-style-type: none"> <li>Outpatient surgery, services &amp; supplies</li> </ul>	30%	All charges except \$540/day
<b>Pregnancy &amp; Maternity Care</b>		
<ul style="list-style-type: none"> <li>Physician office visits</li> </ul> <p>Normal delivery, cesarean section, complications of pregnancy &amp; abortion <i>(newborn routine nursery care covered when natural mother is subscriber or spouse)</i></p> <ul style="list-style-type: none"> <li>Inpatient physician services</li> <li>Hospital &amp; ancillary services</li> </ul>	\$30/visit plus 30% for all other services  30% 30%	50% <sup>f</sup>  50% <sup>f</sup> 50% <sup>f</sup>
<b>Infertility Services</b> <sup>s</sup> <i>(limited to \$2,000/lifetime)</i>	\$500 <sup>††</sup> plus 30% of balance	\$500 <sup>††</sup> plus 50% <sup>f</sup> of balance
<b>Mental or Nervous Disorders and Substance Abuse</b> <sup>t</sup>		
<ul style="list-style-type: none"> <li>Facility-based care <i>(pre-service review required; limited to 30 days per year, in and out of network combined)</i></li> <li>Professional services <i>(One visit per day, 20 visits per year, in network and out of network combined; pre-service review required after the 12th visit)</i></li> </ul>	30% <sup>††</sup> 30% <sup>††</sup>	50% <sup>f</sup> <sup>††</sup> 50% <sup>f</sup> <sup>††</sup>
<b>Home Health Care</b> <i>(pre-service review required)</i>		
<ul style="list-style-type: none"> <li>Services &amp; supplies from a home health agency <i>(limited to 100 four-hour visits/calendar year)</i></li> </ul>	30%	All charges except \$75/visit

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Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay
<b>Infusion Therapy<sup>s</sup> (pre-service review required)</b> <ul style="list-style-type: none"> <li>Includes chemotherapy</li> </ul>	30%	All charges in excess of \$50/day for expenses except drugs; all charges over wholesale cost of infusion therapy drugs; combined limit \$500/ day
<b>Prescription Drugs</b>		
<b>Participating Retail Pharmacy (30-day supply)<sup>†</sup></b> <ul style="list-style-type: none"> <li>Generic drugs</li> <li>Brand name drugs<sup>††</sup></li> <li>Self-administered injectable drugs, except insulin</li> </ul> <b>Non-participating Pharmacies (30-day supply)<sup>†</sup></b> <ul style="list-style-type: none"> <li>In California</li> <li>Outside California</li> </ul>	\$10 copay \$25 copay for formulary; \$40 copay for non-formulary 30% of negotiated fee up to \$100 per fill	50% of the Drug limited fee schedule plus charges in excess of Drug limited fee schedule Copay above plus charges in excess of Drug limited fee schedule
<b>Mail Service (90-day supply)<sup>†</sup></b> <ul style="list-style-type: none"> <li>Generic drugs</li> <li>Brand name drugs<sup>††</sup></li> </ul>	\$10 copay \$50 copay for formulary; \$80 copay for non-formulary	

**Additional information about your outpatient prescription drug benefits:**

- 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 is a brief review of benefits. Once enrolled, members will receive a 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.

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 Customary & Reasonable (C&R).
- †† Does not apply to Out-of-pocket Maximum. Please see the EOC or Certificate for complete information.
- ‡‡ When a member selects a brand name drug when a generic drug is available, and the physician does not write a "dispense as written" or "do not substitute" prescription, the member will be responsible for the generic copay plus the difference in cost between the brand name drug and the generic equivalent.
- §§ 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** 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 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, 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. 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 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 and substance abuse (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. 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*. 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. 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 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 Combined Evidence of Coverage and Disclosure Form. Care or treatment provided in a noncontracting hospital. Private duty nursing except as specifically stated in the Combined Evidence of Coverage and Disclosure Form. 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 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. Contraceptive drugs are not medically appropriate.

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](http://anthem.com/ca).

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