Your Summary of Benefits
Elements Hospital Plans

Small Group Elements Hospital Plan

Effective 10/2011

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

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.

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 *(PPO/non-PPO deductibles are exclusive of each other; in a family, a member only needs to satisfy the individual deductible, not the entire family deductible, prior to receiving plan benefits. Deductible must be met before covered amounts apply, except when deductible is waived.)*	
• Participating Providers & Other Health Care Providers	$2,000/member; $4,000/family
• Non-Participating Providers	$4,000/member; $8,000/family
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/non-PPO out-of-pocket maximums are exclusive of each other; includes calendar year deductible; for a family, a member can receive 100% benefits for covered services once the individual amount is met and does not have to contribute more than the individual amount)*	
• Participating Providers & Other Health Care Providers	$5,000/member; $10,000/family
• Non-Participating Providers	$9,000/member; $18,000/family

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‡‡
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 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℠ Screenings *(where available):* Certain lab tests,	No copay	Not applicable

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Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[‡‡]
immunizations and health education information	(*deductible waived*)	
Physician Medical Services		
• Office visits *(includes retail health clinic & online clinic visit)*[§§]	Not covered	Not covered
• Hospital & skilled nursing facility visits	30%	50%
• Surgeon & surgical assistant; anesthesiologist or anesthetist	30%	50%
Physical Therapy, Occupational Therapy & Chiropractic Services	Not covered	Not covered
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	Not covered	Not covered
Advanced Imaging *(pre-service review required)*	Not covered	Not covered
Emergency Care		
• Emergency room services & supplies *($150 copayment waived if admitted)*	30%	30%
• Physician services	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	30%	50% *(benefit limited to $650/day)*
• Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	30%	50% *(benefit limited to $380/admit)*
Skilled Nursing Facility (*pre-service review required*)		
• Semi-private room, services & supplies *(100 days per year, in-network and out-of-network combined)*	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 pre-service review)*	30% *(limited to $750/trip)*	50% *(limited to $750/trip)*
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[‡‡]
Pregnancy & Maternity Care • Physician office visits Normal delivery, cesarean section, complications of pregnancy & abortion *(newborn routine nursery care covered when natural mother is insured employee or spouse/domestic partner).* Refer to the Physician & Hospital Medical Services benefits for both inpatient and outpatient hospital coverage.	Not covered	Not covered
Infertility Services *(additional $500 copay applies[ƒ]; limited to $2,000/lifetime; no benefits are available for outpatient professional services, lab or x-rays)*[§] • Inpatient hospital services & supplies • Outpatient facility services & supplies • Inpatient professional services	 30% 30% 30%	 50% *(benefit limited to$650/day)* 50% *(benefit limited to $380/admit)* 50%
Mental or Nervous Disorders and Substance Abuse[‡] • Facility-based care *(pre-service review required; limited to 30 days/calendar year, in and out of network combined)* • Professional Services	30% Not covered	50% *(benefit limited to $175/day)* Not covered
Durable Medical Equipment *(pre-service review may be required)*	Not covered	Not covered
Home Health Care *(pre-service review required)* • Services & supplies from a home health agency *(100 four-hour visits per year, in-network and out-of-network combined)*	30%	50% *(benefit limited to $75/visit)*
Infusion Therapy[§] *(pre-service review required)* • Includes chemotherapy	30%	50% *(benefit limited to $50/day of expenses except drugs; all charges over wholesale cost of infusion therapy drugs; combined limit $500/day)*
Prescription Drugs[††] This prescription drug plan includes coverage for drugs on the GenRx Prescription Drug Formulary only. You are responsible for the full cost of all other prescription drugs. The formulary list is furnished to your provider and is also available online at ww.anthem.com/ca, click on Customer Care, Download Forms and then choose GenRx Formulary. You may also contact our pharmacy customer service at 800-700-2533. • Calendar Year Pharmacy Deductible • Infertility Drug Lifetime Maximum	No deductible $1,500/member	
Retail Participating Pharmacy *(30-day supply)*[†] • Preventive Immunizations administered by a retail pharmacy	No copay Not covered Not covered	
• Generic drugs	$10	

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Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay‡‡
• Brand name drugs	Not covered	
• Generic self-administered injectable drugs except insulin	30% of maximum allowed amount up to $150 copayment max per fill	
Non-Participating Pharmacies *(30-day supply)* †		
• In California	50% of the prescription drug maximum allowed amount plus excess charges	
• Outside of California	Copay above plus all charges in excess of prescription drug maximum allowed amount	
Mail Order *(90-day supply)* †		
• Generic drugs	$10	
• Brand name drugs	Not covered	

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

- Preventive flu and pneumonia vaccine obtained from a retail pharmacy
- Outpatient generic drugs and medications which federal and/or state of California law restrict to sale by Prescription only.
- Insulin. Diabetic supplies such as syringes prescribed and dispensed for use with insulin, and 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 infertility are limited to our lifetime maximum payment of $1,500 per member.

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).

† 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.

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

f Does not apply to Out-of-pocket Maximum. Please see the EOC or Certificate for complete information.

†† For generic drugs listed on the Generic Drug Formulary.

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

§§ Pre-service review required after the 12th visit for services of severe mental illness and serious emotional disturbances of a child

Elements Hospital PPO Plan - Exclusions and 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

Prescription drugs that are not listed on the Small Group GenRx Formulary.

Brand name drugs except as listed on the Small Group 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 (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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