Your Summary of Benefits
High Deductible EPO Plan

Anthem Blue Cross

Small Group High Deductible EPO Plan

Effective 2/2011

As an EPO (Exclusive Provider Organization) plan, comprehensive medical and pharmacy benefits are available only through in-network Anthem Blue Cross PPO (Prudent Buyer) providers, unless an authorized referral is received or in a medical emergency. This plan is compatible with a Health Savings Account (HSA) which allows eligible employees to take advantage of tax benefits. Separate from the health plan, an HSA is a convenient, optional way for a member to pay for qualified health care expenses on a tax-favored basis. Individuals considering enrollment in the High-Deductible EPO Plan to use with an HSA, should first consult their tax advisor.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 Combined Evidence of Coverage and Disclosure Form.

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:

Participating Providers-PPO-negotiated rates. Members are not responsible for the difference between the provider's usual charges & the negotiated amount.

Non-Participating Providers & Other Eligible Health Care Providers (includes those not represented in the PPO provider network) **-** For services covered only with an authorized referral or in a medical emergency - The customary & reasonable charge for professional services or the reasonable charge for institutional services.

Participating Pharmacies & Mail Service Program - Prescription drug negotiated rates. Members are not responsible for any amount in excess of the prescription drug negotiated rate.

When using non-participating providers and other eligible health care providers, the member is responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay. When using the outpatient prescription drug benefits, the member is always responsible for drug expenses which are not covered under this plan, as well as any deductible, percentage or dollar copay.

Calendar year deductible (*applicable to medical care & prescription drug benefits*)	
Individual member	$2,000/member
Insured family (*includes insured employee & one or more members of the employee's family; no coverage may be paid for any family member unless this $4,000 deductible is met*)	$4,000/family aggregate[f]
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 is not obtained	$250/admission, treatment or therapy (waived for emergency admission)
Annual Out-of-Pocket Maximums (*includes calendar year deductible & prescription drug covered expense*)	
• Participating Providers, Participating Pharmacy & Other Eligible Health Care Providers	$3,100/single person; $5,700/family aggregate[f]

The following do not apply to out-of-pocket maximums: costs in excess of the covered expense & non-covered expense, amounts paid for acupuncture/acupressure and mental or nervous disorders and substance abuse (except for treatment of severe mental illness and serious emotional disturbances of a child). After a member reaches the out of pocket maximum for all medical and prescription drug covered expense 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 Combined Evidence of Coverage and Disclosure Form. The member remains responsible for costs in excess of the covered expense when provided by non-participating providers and other eligible health care providers; non covered expense, and copays for acupuncture/acupressure and mental or nervous disorders and substance abuse (except for treatment of severe mental illness and serious emotional disturbances of a child).

Lifetime Maximum	Unlimited

Traditional Health Coverage

Member Copay after Calendar Year Deductible (*unless as stated otherwise*)

Covered Services	In-Network	Out-of-Network
Preventive Care[‡‡] *Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits*		
• Routine physical exams, immunizations, diagnostic x-ray & lab for routine physical exam	No copay *(deductible waived)*	Not covered
• Adult Preventive Services *(including mammograms, pap smears, prostate & colorectal cancer screenings)*	No copay (*deductible waived*)	Not covered
• HealthyCheck℠ Screenings *(where available):* Certain lab tests, immunizations and health education information	No copay (*deductible waived*)	Not applicable
Physician Medical Services		
• Office & home visits	20%	Not covered
• Hospital & skilled nursing facility visits	20%	Not covered
• Surgeon & surgical assistant; anesthesiologist or anesthetist	20%	Not covered
Physical Therapy, Physical Medicine & Occupational Therapy, including Chiropractic Services (*limited to combined 12 visits/ calendar year*)	20%	Not covered
Acupuncture/Acupressure		
• Services for the treatment of disease, illness or injury (*limited to 24 visits/calendar year*)	All of negotiated fee except $30/visit[§]	Not covered
Diagnostic X-Ray & Lab (*pre-service review required for certain diagnostic procedures*)	20%	Not covered
Emergency Care		
• Emergency room services & supplies	20%	20% of C&R charges, plus 100% of excess charges
• Inpatient hospital services & supplies	20%	20% of C&R charges, plus 100% of excess charges
• Physician services	20%	20% of C&R charges, plus 100% of excess charges
Hospital Medical Services (*preservice review required*)		
• Semi-private room, meals & special diets, & ancillary services	20%	Not covered
• Outpatient medical care, surgical services & supplies (*hospital care other than emergency room care*)	20%	Not covered
Skilled Nursing Facility (preservice review required)		
• Semi-private room, services & supplies (*limited to 100 days/ calendar year*)	20%	Not covered
Ambulance • Ground or air ambulance transportation, services & disposable supplies	20%	In an emergency or with an authorized referral: 20% of customary & reasonable (C&R) plus all charges in excess of C&R. Non-emergency or no referral: Not covered
Ambulatory Surgical Centers (*pre-service review required*)		
• Outpatient surgery, services & supplies	20%	Not covered
Pregnancy & Maternity Care		
• Physician office visits	20%	Not covered

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Covered Services	In-Network	Out-of-Network
Normal delivery, cesarean section, complications of pregnancy & abortion (*newborn routine nursery care covered when natural mother is insured employee or spouse/domestic partner*)		
• Inpatient physician services	20%	Not covered
• Hospital & ancillary services	20%	Not covered
Infertility Services (*limited to $2,000/lifetime benefit*)	$500 copay plus 20% of balance	Not covered
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*)	20%	Not covered
• Professional services (*one visit per day, 20 visits/calendar year, in and out of network combined*)	20%	Not covered
Home Health Care (*pre-service review required*)		
• Services & supplies from a home health agency (*limited to 90 four-hour visits/calendar year*)	20%	Not covered
Infusion Therapy (*pre-service review required*)		
• Includes chemotherapy	20%	Not covered
Prescription Drugs (*subject to calendar year deductible*)		
Participating Retail Pharmacy (30-day supply)†		
• Generic	$10 copay	
• Brand name drugs††	$25 copay	
• Self-administered injectable drugs (*except insulin*)	30% of negotiated fee	
Non-participating Pharmacies (30-day supply)†		Not covered
Mail Service (60-day supply)†		
• Generic	$10 copay	
• Brand name drugs††	$50 copay	

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.

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.

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

f Once one or more family members' eligible covered expenses (combined) meet this amount, the requirement is satisfied for all covered family members.

†† 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 brand 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.

Outpatient prescription drug services and supplies are not provided for or in connection with the following: 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.

EPO Plan - Exclusions and LimitationsFollowing is an abbreviated list of exclusions and limitations; please see the Certificate for comprehensive details.Any amounts in excess of maximums stated in the CertificateServices or supplies that are not medically necessaryServices received before your effective dateServices received after your coverage endsAny conditions for which benefits can be recovered under any workers' compensation law or similar lawServices you receive for which you are not legally obligated to payServices for which no charge is made to you in the absence of insurance coverageServices not listed as covered in the CertificateServices from relativesVision care except as specifically stated in the CertificateEye surgery performed solely for the purpose of correcting refractive defectsHearing aids. Routine hearing tests except as specifically stated in the CertificateSex changesDental and orthodontic services except as specifically stated in the CertificateCosmetic surgeryRoutine physical examinations except as specifically stated in the CertificateTreatment of mental or nervous disorders and substance abuse (including nicotine use) or psychological testing, except as specifically stated in the CertificateCustodial careExperimental or investigational servicesServices provided by a local, state or federal government agency, unless you have to pay for themDiagnostic admissionsTelephone or facsimile machine consultationsPersonal comfort itemsNutritional counselingHealth club membershipsCommercial weight loss programsMedical supplies and equipment/durable medical equipment, except as specifically stated in the CertificateSpecialty drugs, except as specifically stated in the CertificateAny services to the extent you are entitled to receive Medicare benefits for those services without payment of additional premium for Medicare coverageFood or dietary supplements, except as specifically stated in the Certificate or as required by lawGenetic testing for non-medical reasons or when there is no medical indication or no family history of genetic abnormalityOutdoor treatment programsReplacement of prosthetics and durable medical equipment when lost or stolenAny services or supplies provided to any person not covered under the Agreement inconnection with a surrogate pregnancyImmunizations solely for travel outside the United StatesServices or supplies related to a pre-existing conditionEducational services except as specifically provided or arranged by Anthem Blue CrossInfertility services (including sterilization reversal) except as specifically stated in the CertificateCare or treatment provided in a non-contracting hospitalPrivate duty nursing except as specifically stated in the CertificateServices primarily for weight reduction except medically necessary treatment of morbid obesityOutpatient drugs, medications or other substances dispensed or administered in any outpatient settingContraceptive 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.

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