Anthem Blue Cross

Classic HMO 30/250/3 day

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 $1,500; Family $3,000

The following copay does not apply to the annual copay maximum:

- for 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	$250/day, up to 3 day maximum
➢ 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	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)*	
➢ 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 100 visits/calendar year; one visit by a home health aide equals four hours or less)*	No copay
Physician Medical Services	
➢ Office & home visits	$30/visit
➢ Hospital visits	No copay
➢ Skilled nursing facility visits	No copay
➢ Specialists & consultants	$30/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)*	$30/visit
Acupuncture	$30/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)*	20% of charges
Preventive Care Services *Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits*	
➢ Complete physical exams & periodic routine checkups when ordered by the primary care physician	No copay
➢ Well-baby & well-child care	No copay
➢ Well-woman exams	No copay
➢ Hearing exams	No copay
➢ Vision exams *(vision screening from primary care physician covers evaluation only; diagnostic & treatment programs, including refractions, from an optometrist or ophthalmologist must be authorized by the primary care physician)*	No copay
Health Education and Wellness Programs	
➢ Specified immunizations	No copay
➢ Allergy testing & treatment *(including serums)*	$30/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	$250/day, up to 3 day maximum
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	$30/visit
➢ Complications of pregnancy or therapeutic abortions	$30/visit
Normal Delivery or Cesarean Section, including:	
➢ Inpatient hospital & ancillary services	$250/day, up to 3 day maximum
➢ Routine nursery care	No copay
➢ Physician services *(inpatient only)*	No copay
Complication of Pregnancy or Therapeutic Abortion, including:	
➢ Inpatient hospital & ancillary services	$250/day, up to 3 day maximum
➢ Outpatient hospital services	No copay
➢ Physician services *(inpatient only)*	No copay
Elective Abortions *(including prescription drug for abortion [mifepristone])*	$150
Genetic Testing of Fetus	No copay
Family Planning Services	
➢ Infertility studies & tests	50% of covered expense[1]
➢ Tubal ligation	$150
➢ Vasectomy	$50
➢ Counseling & consultation	No copay
Organ and Tissue Transplant	
➢ Inpatient Care	$250/day, up to 3 day maximum
➢ Physician office visits *(including primary care, specialty care & consultants)*	$30/visit
Mental or Nervous Disorders and Substance Abuse	
Inpatient Care	
➢ Facility-based care *(pre-authorization required)*	$250/day, up to 3 day maximum
➢ Physician hospital visits	No copay
Outpatient Care	
➢ Facility-based care *(pre-authorization required)*	No copay
➢ Outpatient physician visits *(pre-service review required after the 12th visit)*	$30/visit
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.

Classic 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.

Crime or Nuclear Energy. Any health problem caused: (1) while committing or trying to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) by nuclear energy, when the government can pay for treatment.

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).

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 Given by Providers Who Are Not With Anthem Blue Cross HMO. We will not cover these services unless primary care doctor refers the member, except for emergencies 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.

Birth Control Devices. Any devices needed for birth control which can be obtained without a doctor's prescription such as condoms.

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).

Chronic Pain Treatment. Treatment of frequent recurrences of pain, over a long period of time, that is not related to an active medical condition currently being treated.

Clinical Trials. Services and supplies in connection with clinical trials, except as specified as covered in the Evidence of Coverage (EOC).

Consultations given by telephone or fax.

Commercial weight loss programs. Weight loss programs, whether or not they are pursued under medical or *doctor* supervision, unless specifically listed as covered in this *plan*.

This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

This exclusion does not apply to *medically necessary* treatments for morbid obesity or for treatment of anorexia nervosa or bulimia nervosa.

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.

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.

Growth Hormones. Growth hormone treatment.

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as provided in this *plan* or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

Health Club Membership. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a *doctor*. This exclusion also applies to health spas.

Hearing Aids. Hearing aids or services for fitting or making a hearing aid, except as specified as covered in the EOC.

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.

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 or nervous disorders. 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.

Orthopedic Shoes. Orthopedic shoes (except when joined to braces) or shoe inserts (except custom molded orthotics). This does not apply to shoes and inserts designed to prevent or treat foot complications due to 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.

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.

Routine Exams. Routine physical or psychological exams or tests asked for by a job or other group, such as a school, camp, or sports program.

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

Sex Change. Sex change surgery or treatments.

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 the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

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.