Your Summary of Benefits
Premier PPO

Custom Premier PPO 250/10/10

This Summary of Benefits is a brief overview of your plan's benefits only. The benefits listed are for both in state and out of state members, there may be differences in benefits depending on where you reside. For more detailed information about the benefits in your plan, please refer to your Certificate of Insurance or Certificate 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. Please review the deductible information below to know if a deductible applies to a specific covered service. Certain Covered Services have maximum visit and/or day limits per year. The number of visits and/or days allowed for these services will begin accumulating on the first visit and/or day, regardless of whether your Deductible has been met. Members are also responsible for all costs over the plan maximums. Plan maximums & other important information appear in italics. Benefits aresubject to all terms, conditions, limitations, and exclusions of the Policy.

Subject to Utilization Review
Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.

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.

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.

When using Non-PPO and Other Health Care Providers, members are responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.

Calendar year deductible for all providers	$250/member; $750/family
Additional deductible for non-Anthem Blue Cross PPO hospital or residential treatment center if utilization review not obtained	$500/admission *(waived for emergency admission)*
Deductible for emergency room services	$100/visit (*waived if admitted directly from ER*)
Annual Out-of-Pocket Maximums *(cross application applies)*	
∘ PPO Providers & Other Health Care Providers	$2,000/member; $4,000/family
∘ Non-PPO Providers	$6,000/member; $12,000/family

The following do not apply to out-of-pocket maximums: non-covered expenses. After an annual out-of-pocket maximum is met for medical and prescription drugs during a calendar year, the individual member or family will no longer be required to pay a copay or coinsurance for medical and prescription drug covered expenses for the remainder of that year. The member remains responsible for non-covered expenses.

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, HIV testing),* and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration. *This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.	No copay *(deductible waived)*	30%
Physician Medical Services • Office & home visits *(includes retail health clinic & online visit)* • Hospital & skilled nursing facility visits • Surgeon & surgical assistant; anesthesiologist or anesthetist • Drugs administered by a medical provider *(certain drugs are subject to utilization review)*	$10/visit (*deductible waived*)[†] 10% 10% 10%	30% 30% 30% 30%
Diabetes Education Programs *(requires physician supervision)* [†] • Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	$10/visit *(deductible waived)*	30%
• **Physical Therapy, Physical Medicine & Occupational Therapy** • **Chiropractic Services** *(limited to 30 visits /calendar year)* [f]	10% $10/visit *(deductible waived)*	30% 30%
Speech Therapy	10%	30%
Acupuncture • Services for the treatment of disease, illness or injury *(limited 20 visits/calendar year)*	$10/visit *(deductible waived)*	30%
Diagnostic X-ray & Lab • Other diagnostic x-ray & lab	10%	30%
Advanced Imaging *(subject to utilization review)*	10%	30% *(benefit limited to $800/procedure)*
Urgent Care *(physician services)* [†]	$10/visit *(deductible waived)*	30%

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay
Emergency Care		
• Emergency room services & supplies *($100 deductible waived if admitted inpatient)*	No copay	No copay
• Physician services	No copay	No copay
Hospital Medical Services *(subject to utilization review for inpatient and certain outpatient services; waived for emergency admissions)*		
• Semi-private or private room, medically necessary services & supplies	10%	30% *(benefit limited to $1,000/day for non-emergency admission)*
• Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	10%	30% *(benefit limited to $350/admit)*
Skilled Nursing Facility *(subject to utilization review)*		
• Semi-private room, services & supplies *(limited to 100 days/calendar year; limit does not apply to mental health and substance abuse)*	10%	30%
Related Outpatient Medical Services & Supplies		
• Ground or air ambulance transportation, services & disposable supplies *(air ambulance in a non-medical emergency is subject to pre-service review and benefit limited to $50,000 for non-PPO)*	10%	In an emergency or with an authorized referral: 10%; Non-emergency: 30%
• Blood transfusions, blood processing & the cost of unreplaced blood & blood products ‡	20%	20%
• Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)* ‡	20%	20%
Ambulatory Surgical Centers *(certain surgeries are subject to utilization review)*		
• Outpatient surgery, services & supplies	10%	30% *(benefit limited to $350/admit)*
Pregnancy & Maternity Care		
• Physician office visits	$10/visit (*deductible waived*)†	30%
• Prescription drug for abortion (*mifepristone*)	10%	30%
Normal delivery, cesarean section, complications of pregnancy & abortion. Refer to the Physician & Hospital Medical Services benefits for both inpatient and outpatient hospital coverage.		
Mental or Nervous Disorders and Substance Abuse		
• Inpatient facility care (*subject to utilization review; waived for emergency admissions*)	10%	30% *(benefit limited to $1,000/day for non-emergency admission)*
• Inpatient physician visits	10%	30%
• Outpatient facility care	10% after deductible is met	30% after deductible is met
• Physician office visits *(Behavioral Health treatment for Autism or Pervasive Development disorders require pre-service review)*	$10/visit (*deductible waived*) †	30% after deductible is met

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay
Durable Medical Equipment *(may be subject to utilization review)* • Rental or purchase of DME *(breast pump and supplies are covered under preventive care at no charge for in-network)*	10%	30%
Home Health Care *(subject to utilization review)* • Services & supplies from a home health agency *(limited to 100 visits/calendar year, one visit by a home health aide equals four hours or less)*	10%	30%
Home Infusion Therapy *(subject to utilization review)* • Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	10%	30% (*benefit limited to $600/day*)
Hemodialysis • Outpatient hemodialysis services & supplies	10%	30% *(benefit limited to $350/visit for free standing hemodialysis center)*
Hospice Care • Inpatient or outpatient services; family bereavement services	No copay *(deductible waived)*	30%
Bariatric Surgery (*subject to utilization review; covered only when performed at a Centers of Medical Excellence [CME] for California; Blue Distinction Centers for Specialty Care [BDCSC] for out of California)* • Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity • Travel expenses for an authorized, specified surgery *(recipient & companion transportation limited to $3,000 per surgery)*	10% No copay (*deductible waived*)	Not covered[§] Not covered[§]
Organ & Tissue Transplants *(subject to utilization review; specified transplants covered only when performed at Centers of Medical Excellence [CME] for California; Blue Distinction Centers for Specialty Care [BDCSC] for out of California)* • Inpatient services provided in connection with non-investigative organ or tissue transplants • Transplant travel expense for an authorized, specified transplant *(recipient & companion transportation limited to $10,000 per transplant)* • Unrelated donor search, limited to $30,000 per transplant	10% No copay (*deductible waived*)	Not covered[§] Not covered[§]
Prosthetic Devices • Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; & therapeutic shoes & inserts for members with diabetes	10%	30%

Certain types of physicians may not be represented in the PPO network in the state where the member receives services. If such physician is not available in the service area, the member's copay is the same as for PPO (with and without pre-notification, if applicable). Member is responsible for applicable copays, deductibles and charges which exceed covered expense.

In addition to the benefits described above, coverage may include additional benefits, depending upon the member's home state. The benefits provided in this summary are subject to federal and California laws. There are some states that require more generous benefits be provided to their residents, even if the master policy was not issued in their state. If the member's state has such requirements, we will adjust the benefits to meet the requirements.

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.

† The dollar copay applies only to the visit itself. An additional copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

‡ These providers may not be represented in the PPO network in the state where the member receives services.

§ Exception: If service is performed at a Centers of Medical Excellence [CME] for California or Blue Distincti Centers for Speciality Care [BDCSC] for out of California, the services will be covered same as the PPO (in-network) benefit.

f Additional visits as authorized if medically necessary; pre-service review must be obtained prior to receiving the services.

For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to https://le.anthem.com/pdf?x=CA_LG_PPO