

Your Summary of Benefits Classic HMO



Classic HMO 30/40/500 Admit/250 OP

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.

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 \$2,500; Family \$5,000

The following copay does not apply to the annual copay maximum: for infertility services

Covered Services	Per Member Copay
<p>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.</p>	No copay
<p>Smoking Cessation Program</p>	No copay
<p>Physician Medical Services</p> <ul style="list-style-type: none"> • Office & home visits \$30/visit • Specialists \$40/visit • Skilled nursing facility visits No copay • Hospital visits No copay • Injectable medications in physician's office (excluding allergy serum and immunization) 30%/up to \$150 maximum copay • Surgeon & Surgical assistant No copay • Anesthesiologist or anesthesiologist No copay 	
<p>Acupuncture</p>	\$30/visit
<p>Outpatient Medical Services (Services received in a hospital, other than emergency room services, or in any facility that is affiliated with a hospital)</p> <ul style="list-style-type: none"> • Outpatient surgery & supplies \$250/admit • Advanced Imaging \$100/test • All other X-ray & laboratory tests (including genetic testing) No copay • Radiation therapy, chemotherapy & hemodialysis treatment & Infusion therapy \$40/visit • Other Outpatient Medical Services including: Rehabilitation Therapy (Physical, Occupational, or Speech Therapy, limited to a 60-day period of care) \$40/visit 	
<p>General Medical Services (when performed in non-hospital-based facility)</p> <ul style="list-style-type: none"> Advanced Imaging \$100/test • All other X-ray & laboratory tests (including genetic testing) No copay • Allergy testing & treatment (including serums) \$30/visit • Radiation therapy, chemotherapy & hemodialysis treatment & Infusion therapy \$40/visit 	

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Covered Services	Per Member Copay
<ul style="list-style-type: none"> Rehabilitation Therapy (Physical, Occupational, or Speech Therapy or Chiropractic Care, limited to 60-days period of care) 	\$30/visit
Emergency Care <ul style="list-style-type: none"> Physician & medical services Outpatient hospital emergency room services 	No copay \$150/visit (<i>waived if admitted inpatient</i>)
Inpatient Medical Services Semi-private room or private room, medically necessary services & supplies	\$500/admit
Urgent Care (out of service area)	\$40/visit (waived if admitted)
Skilled Nursing Facility <i>(limited to 100 days/calendar year)</i> <ul style="list-style-type: none"> All necessary services & supplies (<i>excluding take-home drugs</i>) 	No copay
Ambulance Services <ul style="list-style-type: none"> Transportation when medically necessary 	\$100/trip
Ambulatory Surgical Center <ul style="list-style-type: none"> Outpatient surgery & supplies 	\$250/admit
Pregnancy and Maternity Care Prenatal & postnatal Professional (physician) services (For your Inpatient copay, see Inpatient Medical Services. For your Outpatient Services copay, see Outpatient Medical Services)	\$30/visit
Elective Abortions (including prescription drug for abortion, mifepristone)	\$150
Prosthetic devices (including Orthotics)	No copay
Durable medical equipment	50%
Family Planning Services <ul style="list-style-type: none"> Inferility studies & tests Tubal ligation Vasectomy Counseling & consultation 	50% of covered expense [†] \$150 \$50 \$30/visit
Mental or Nervous Disorders and Substance Abuse Inpatient Care <ul style="list-style-type: none"> Facility-based care (<i>pre-authorization required</i>) Physician hospital visits Outpatient Care <ul style="list-style-type: none"> Facility-based care (<i>pre-authorization required</i>) Outpatient physician visits (<i>pre-service review required after the 12th visit</i>) 	\$500/admit No copay No copay \$30/visit
Home Health Care <i>(limited to 100 visits/calendar year; one visit by a home health aide equals four hours or less)</i>	\$30/visit
Hospice Care (<i>Inpatient or outpatient services; family bereavement services</i>)	No copay
Organ and Tissue Transplant <ul style="list-style-type: none"> Inpatient Care Physician office visits Specialist office visit 	\$500/admit \$30/visit \$40/visit

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).

† Not applicable to the annual copay maximum

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 orthotics, 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.

Sex Change. Sex change surgery or treatments.

Sexual Problems. Treatment of any sexual problems unless due to a medical problem, physical defect, or disease.

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

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.

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Your Summary of Benefits Prescription Drug Plan



\$15/\$30/\$50/30% \$250 Deductible

PLEASE NOTE: *This is only a summary of your benefits. Please refer to your Combined Evidence of Coverage and Disclosure Form ("EOC")/Certificate of Insurance ("Certificate") which explains your plan's Exclusions and Limitations as well as the full range of your covered services in detail.*

Getting a Prescription Filled at a Participating Pharmacy

To get a prescription filled, you need only take your prescription to a participating pharmacy and present your ID card. The amount you pay for a covered prescription - your copay - will be determined by which formulary tier the drug falls into (a description of the drug tiers is listed below).

A generic drug contains the same effective ingredients, meets the same standards of purity as its brand-name counterpart and typically costs less. In many situations, you have a choice of filling your prescription with a generic medication or a brand-name medication. You may have to pay an additional charge that represents the cost difference between the brand-name medication and the generic equivalent.

The formulary is a list of recommended brand and generic medications. Drugs on the formulary are grouped by 'tiers.' A number of factors are considered when classifying drugs into tiers, including, but not limited to: the absolute cost of the drug; the cost of the drug relative to other drugs in the same therapeutic class; the availability of over-the-counter alternatives; and other clinical and cost-effectiveness factors.

Tier 1 - Lowest copayment - Drugs offering the greatest value within a therapeutic class. Some of these are generic equivalents of brand name drugs.

Tier 2 - Medium copayment - Drugs on this tier are generally the more affordable brand-name drugs. Other drugs are on this tier because they are "preferred" within their therapeutic classes, based on clinical effectiveness and value.

Tier 3 - Highest copayment - These are higher cost brand-name drugs. Some Tier 3 drugs may have generics or equivalents in Tier 1. In addition, some drugs on this tier may have been evaluated to be less cost-effective than equivalent drugs on lower tiers.

Tier 4 - Many drugs on this tier are "specialty" drugs used to treat complex, chronic conditions and may require special handling and/or management.

Copies of our tiered drug formulary list are furnished to your providers. They are updated quarterly and are available online at www.anthem.com/ca, click on Customer Care, Download Forms and then choose Anthem Blue Cross Drug List (tiered). You or your provider may also contact our Pharmacy Customer Service at 800-700-2541.

Finding a Participating Pharmacy

Because our huge pharmacy network includes major drugstore chains plus a wide variety of independent pharmacies, it is easy for you to find a

participating pharmacy. You can also find a participating pharmacy by calling Pharmacy Customer Service at 800-700-2541 or by going to our Web site at anthem.com/ca.

Using a Participating Pharmacy

You can control the cost of your prescription drugs by using our network of participating pharmacies. Participating pharmacies have agreed to charge you not more than the prescription drug maximum allowed amount.

Using a Non-Participating Pharmacy

If you choose to fill your prescription at a non-participating pharmacy, your costs may increase. You will likely need to pay for the entire amount of the prescription and then submit a prescription drug claim form for reimbursement to us.

Members that submit claims from non-participating pharmacies are reimbursed based on the lesser of the billed charge or on a prescription drug maximum allowed amount. The prescription drug maximum allowed amount may be considerably less than you paid for your medication. You are responsible for paying any difference in cost between the prescription drug maximum allowed amount and what you paid for your medication.

You may obtain a prescription drug claim form by calling Pharmacy Customer Service at the toll-free number printed on your member ID card or by going to our Web site at anthem.com/ca.

Mail Service Prescription Drug Program

If you take a prescription drug on a regular basis, you may want to take advantage of our mail service program. To fill a prescription through the mail, simply complete the Mail Service Prescription form. You may obtain the form by calling Customer Service, at the toll-free number listed on your ID card or by going to our Web site at anthem.com/ca.

Please note that not all medications are available through the Mail Service Program. Specialty pharmacy drugs are not available through the mail service program, see Specialty Pharmacy Program below.

Specialty Pharmacy Program

Specialty medications are usually dispensed as an injectable drug, but may be available in other forms, such as a pill or inhalant. They are used to treat complex conditions. Prescriptions for a specialty pharmacy drug are covered only when ordered through the specialty pharmacy program unless you are given an exception from the specialty drug program (see your EOC/Certificate for details). The specialty pharmacy program will deliver your medication to you by mail or common carrier (you cannot pick up your medication).

You may have to pay the full cost of a specialty pharmacy drug if it is not obtained from the specialty pharmacy program.

Specialty drugs are limited to a 30-day supply for each fill.

Covered Services (outpatient prescriptions only)	Per Member Copay for Each Prescription or Refill
Calendar Year Pharmacy Deductible⁵	\$250/member; Maximum of three separate deductibles/family
Retail Participating Pharmacy <ul style="list-style-type: none"> • Preventive immunizations administered by a retail pharmacy • Tier 1 drugs (<i>includes diabetic supplies</i>) • Tier 2 drugs [†] • Tier 3 drugs (<i>includes compound drugs</i>)[†] 	No copay (<i>deductible waived</i>) \$15 (<i>deductible waived</i>) \$30 \$50
Mail Service <ul style="list-style-type: none"> • Tier 1 drugs (<i>includes diabetic supplies</i>) • Tier 2 drugs [†] • Tier 3 drugs ^{† f} 	\$15 (<i>deductible waived</i>) \$60 \$100
Specialty Pharmacy Drugs (<i>may only be obtained through the specialty pharmacy program</i>) <ul style="list-style-type: none"> • Tier 4 drugs • Tier 4 Out of Pocket Maximum Tier 4 prescription drug copayments will accrue to a maximum of \$3,500 per member per year. Once the member has satisfied the \$3,500 maximum, no additional copayments will be required for the remainder of the year for Tier 4 prescription drugs 	30% of prescription drug maximum allowed amount (<i>maximum \$150 copay per fill</i>)
Non-participating Pharmacies (<i>compound drugs & specialty pharmacy drugs not covered</i>)	Member pays the full retail price of the prescription drug and submits claim form to us for reimbursement. We will reimburse 50% of the remaining prescription drug maximum allowed amount less any pharmacy deductible (if applicable), the above retail pharmacy copay & costs in excess of the prescription drug maximum allowed amount.
Supply Limits[‡] <ul style="list-style-type: none"> • Retail Pharmacy (<i>participating and non-participating</i>) • Mail Service • Specialty Pharmacy 	30-day supply; 60-day supply for federally classified Schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies) 90-day supply 30-day supply

The Prescription Drug Benefit covers the following:

- Preventive flu and pneumonia vaccines administered by a participating retail pharmacy
 - Outpatient prescription drugs and medications which the law restricts to sale by prescription. Formulas prescribed by a physician for the treatment of phenylketonuria.
 - Insulin
 - Syringes when dispensed for use with insulin and other self-injectable drugs or medications
 - Prescription oral contraceptives; contraceptive diaphragms. Contraceptive diaphragms are limited to one per year and will be subject to a tier 2 or tier 3 copay.
 - Injectable drugs which are self-administered by the subcutaneous route (under the skin) by the patient or family member. Drugs that have Food and Drug Administration (FDA) labeling for self-administration
 - All compound prescription drugs that contain at least one covered prescription ingredient.
 - Diabetic supplies (i.e., test strips and lancets)
 - Prescription drugs for treatment of impotence and/or sexual dysfunction are limited to organic (non-psychological) causes.
 - Inhaler spacers and peak flow meters for the treatment of pediatric asthma. These items are subject to the copay for tier 2 or tier 3 copay.
 - Certain over-the-counter drugs approved by the Pharmacy and Therapeutics Committee to be included in the prescription drug formulary.
- Prescription drug copays are separate from the medical copays of the medical plan and are not applied toward the Annual Out-of-Pocket Maximums under the Medical Plan.**

- †** Preferred Generic Program. If a member requests a brand name drug when a generic drug version exists, the member pays the generic drug copay plus the difference in cost between the prescription drug maximum allowed amount for the generic drug and the brand name drug dispensed, but not more than 50% of our average cost of that type of prescription drug. The Preferred Generic Program does not apply when the physician has specified "dispense as written" (DAW) or when it has been determined that the brand name drug is medically necessary for the member. In such case, the applicable copay for the dispensed drug will apply.
- ‡** Supply limits for certain drugs may be different. Please refer to the EOC/Certificate for complete information
- §** Members are responsible to pay the prescription drug maximum allowed amount until the pharmacy deductible is met unless deductible is specifically waived. Once the pharmacy deductible is met, members are responsible for the copay amount.
- f** Compound drugs are not covered through mail service; only covered through certain retail participating pharmacies.

Prescription Drug Exclusions & Limitations

Immunizing agents, biological sera, blood, blood products or blood plasma.

Hypodermic syringes &/or needles, except when dispensed for use with insulin & other self-injectable drugs or medications.

Drugs & medications used to induce spontaneous & non-spontaneous abortions.

Drugs & medications dispensed or administered in an outpatient setting, including outpatient hospital facilities and physicians' offices.

Professional charges in connection with administering, injecting or dispensing drugs.

Drugs & medications that may be obtained without a physician's written prescription, except insulin or niacin for cholesterol lowering and certain over-the-counter drugs approved by the Pharmacy and Therapeutics Committee to be included in the prescription drug formulary.

Drugs & medications dispensed by or while confined in a hospital, skilled nursing facility, rest home, sanatorium, convalescent hospital or similar facility.

Durable medical equipment, devices, appliances & supplies, even if prescribed by a physician, except contraceptive diaphragms, as specified as covered in the EOC/Certificate.

Services or supplies for which the member is not charged.

Oxygen.

Cosmetics & health or beauty aids. However, health aids that are medically necessary and meet the requirements as specified as covered in the EOC/Certificate. Drugs labeled "Caution, Limited by Federal Law to Investigational Use," or experimental drugs.

Drugs or medications prescribed for experimental indications Any expense for a drug or medication incurred in excess of the prescription drug maximum allowed amount.

Drugs which have not been approved for general use by the State of California Department of Health or the Food and Drug Administration. This does not apply to drugs that are medically necessary for a covered condition.

Drugs to eliminate or reduce dependency on, or addiction to, tobacco and tobacco products. This does not apply to medically necessary drugs that the member can only get with a prescription under state and federal law.

Drugs used primarily for cosmetic purposes (e.g., Retin-A for wrinkles). However, this will not apply to the use of this type of drug for medically necessary treatment of a medical condition other than one that is cosmetic.

Drugs used primarily to treat infertility (including, but not limited to, Clomid, Pergonal and Metrodin), unless medically necessary for another condition.

Anorexiants and drugs used for weight loss, except when used to treat morbid obesity (e.g., diet pills & appetite suppressants).

Drugs obtained outside the U.S, unless they are furnished in connection with urgent care or an emergency.

Allergy desensitization products or allergy serum.

Infusion drugs, except drugs that are self-administered subcutaneously.

Herbal supplements, nutritional and dietary supplements except for formulas for the treatment of phenylketonuria.

Prescription drugs with a non-prescription (over-the-counter) chemical and dose equivalent except insulin. This does not apply if an over-the-counter equivalent was tried and was ineffective.

Compound medications unless:

- a. There is at least one component in it that is a prescription drug; and
- b. It is obtained from a participating pharmacy. Member will have to pay the full cost of the compound medications if member obtains drug at a non-participating pharmacy.

Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but which are obtained from a retail pharmacy are not covered by this plan. Member will have to pay the full cost of the specialty pharmacy drugs obtained from a retail pharmacy that member should have obtained from the specialty pharmacy program.

Third Party Liability

Anthem Blue Cross is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

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