Custom BC Premier PPO 500/80/70 ETSM

BC PPO Benefits

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. In addition to dollar and percentage copays, insured persons are responsible for deductibles, as described below. Please review the deductible information 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. Insured persons 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 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	$500/insured person; $1,000/family	
Copay for non-PPO hospital	$500/admission *(waived for emergency admission)*	
Copay for hospital if utilization review not obtained	$500/admission *(waived for emergency admission)*	
Copay for emergency room services	$100/visit *(waived if admitted directly from ER)*	
Annual Out-of-Pocket Maximums *(no cross application)*		
PPO & Other Health Care Providers	$2,000/insured person/year; $6,000/family/year	
Non-PPO Providers	$3,000/insured person/year; $9,000/family/year	
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 Insured Person Copay**	**Non-PPO: Per Insured Person Copay**
Hospital Medical Services *(subject to utilization review for inpatient service; waived for emergency admissions)*		
➢ Semi-private room, meals & special diets, & ancillary services	20%	30% *(benefit limited to $1,000/day for non-emergency admission)*
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	20%	30% *(benefit limited to $350/admit)*
Ambulatory Surgical Centers		
➢ Outpatient surgery, services & supplies	20%[1]	30%[1] *(benefit limited to $350/day)*
Hemodialysis		
➢ Outpatient hemodialysis services & supplies	20%[1]	30%[1] *(benefit limited to $350/day)*
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)*	20%[1]	30%[1]
Hospice Care		
➢ Inpatient or outpatient services for insured persons; family bereavement services	20%[2]	

[1] These providers may not be represented in the PPO network in the state where the insured person receives services. If such provider is not available in the service area, the insured person's copay is the same as for PPO. All copays are in addition to applicable deductibles.

[2] These providers may not be represented in the PPO network in the state where an insured person receives services. If such provider is not available in the service area, the insured person's copay is 20%. If such provider is available in the service area and the insured person receives services from a PPO provider, the insured person's copay is 20%.However, if the insured person chooses to receive services from a non-PPO provider when such provider is available in the service area, the insured person's copay is 30%. All copays are in addition to applicable deductibles.

Covered Services	PPO: Per Insured Person Copay	Non-PPO: Per Insured Person Copay
Home Health Care		
➢ 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; not covered while insured person receives hospice care)*	20%[1]	30%[1]
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	20%[1]	30%[1] *(benefit limited to $600/day)*
Physician Medical Services		
➢ Office & home visits	20%	30%
➢ Hospital & skilled nursing facility visits	20%	30%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	20%	30%
Diagnostic X-ray & Lab		
➢ MRI, CT scan, PET scan & nuclear cardiac scan *(subject to utilization review)*	20%[1]	30%[1]
➢ Other diagnostic x-ray & lab	20%[1]	30%[1]
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%
Physical Therapy, Physical Medicine & Occupational Therapy	20%	30%
Chiropractic Services *(limited to 30 visits/calendar year; additional visits may be authorized)*	20% *(deductible waived)*	30%
Speech Therapy		
➢	20%	30%
Acupuncture		
➢ Services for the treatment of disease, illness or injury *(limited to 20 visits/calendar year)*	20%[2] *(deductible waived)*	30%[2]
Temporomandibular Joint Disorders		
➢ Splint therapy & surgical treatment	20%	30%
Pregnancy & Maternity Care		
➢ Physician office visits	20%	30%
➢ Prescription drug for abortion *(mifepristone)*	20%	30%
Normal delivery, cesarean section, complications of pregnancy & abortion		
➢ Inpatient physician services	20%	30%
➢ Hospital & ancillary services	20%	30%
Organ & Tissue Transplants *(subject to utilization review; specified transplants covered only when performed at Centers of Medical Excellence [CME] and Blue Distinction Centers for Specialty Care [BDCSC] 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	20%	30%
➢ Unrelated donor search, limited to $30,000 per transplant		

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[2] Acupuncture services can be performed by a certified acupuncturist (C.A.), a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a podiatrist (D.P.M.), or a dentist (D.D.S.).

Covered Services	PPO: Per Insured Person Copay	Non-PPO: Per Insured Person Copay
Diabetes Education Programs *(requires physician supervision)*		
➢ Teach insured persons & their families about the disease process, the daily management of diabetic therapy & self-management training	20%	30%
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 insured persons with diabetes	20%	30%
Durable Medical Equipment		
➢ Rental or purchase of DME including hearing aids, dialysis equipment & supplies *(hearing aids benefit available for one hearing aid per ear every three years; breast pump and supplies are covered under preventive care at no charge for in-network)*	20%[1]	30%[1]
Related Outpatient Medical Services & Supplies		
➢ Ground or air ambulance transportation, services & disposable supplies	20%[2]	
➢ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	20%[2]	
➢ Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)*	20%[2]	
Emergency Care		
➢ Emergency room services & supplies *($100 copay waived if admitted)*	20%	20%
➢ Inpatient hospital services & supplies	20%	20%
➢ Physician services	20%	20%
Mental or Nervous Disorders and Substance Abuse		
➢ Inpatient facility care *(subject to utilization review; waived for emergency admissions)*	20%	30%[1] *(benefit limited to $1,000/day for non-emergency admission)*
➢ Inpatient physician visits	20%	30%
➢ Outpatient facility care	20% *(after deductible is met)*	30%[1] *(after deductible is met)*
➢ Physician office visits *(Behavioral Health treatment for Autism or Pervasive Development disorders require pre-service review)*	20% *(deductible waived)*	30% *(after deductible is met)*

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In addition to the benefits described above, coverage may include additional benefits, depending upon the insured person'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 insured person's state has such requirements, we will adjust the benefits to meet the requirements.

This Summary of Benefits is a brief review of benefits. Once enrolled, insured persons will receive a Certificate of Insurance, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.

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