Custom BC Premier PPO 500/20 30/20 ETSM
Loyola Marymount University/RSHM-Actives

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the ecently 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. Participating 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-Participating Providers & Other Health Care Providers-(includes those not represented in the PPO provider network)-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. For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement may be 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, insured persons are responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.

Calendar year deductible *(no cross application)*	
PPO & Other Health Care Providers	$500/insured person$1,000/family
Non-PPO Providers	$1,000/insured person; $2,000/family
Deductible for non-PPO hospital	$500/admission *(waived for emergency admission)*
Deductible for hospital 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 *(no cross application)*	
PPO & Other Health Care Providers	$3,000/insured person/year; $6,000/family/year
Non-PPO Providers	$6,000/insured person/year; $12,000/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	$200/admission + 20%	40%
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	20%	40%
Ambulatory Surgical Centers		
➢ Outpatient surgery, services & supplies	20%[1]	40%[1] *(benefit limited to $350/day)*
Hemodialysis		
➢ Outpatient hemodialysis services & supplies	20%[1]	40%[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]	40%[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 40%. 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]	40%[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]	40%[1] *(benefit limited to $600/day)*
Physician Medical Services		
➢ Office & home visits *(includes retail health clinics and online visits)*	$20/visit[2] *(deductible waived)*	40%
➢ Specialists	$30/visit[2] *(deductible waived)*	40%
➢ Hospital & skilled nursing facility visits	20%	40%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	20%	40%
➢ Drugs administered by a medical provider *(certain drugs are subject to utilization review)*	20%	40%
Diagnostic X-ray & Lab		
➢ MRI, CT scan, PET scan & nuclear cardiac scan *(subject to utilization review)*	20%[1]	40%[1]
➢ Other diagnostic x-ray & lab	20%[1]	40%[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.		
➢ Routine physical exams *(birth through age six)*	No copay *(deductible waived)*	40% *(benefit limited to $20/exam)*
➢ Immunizations *(birth through age six)*	No copay *(deductible waived)*	40% *(benefit limited to $12/immunization)*
➢ Routine physical exams, immunizations, diagnostic X-ray & lab for routine physical exam *(members 7 years old and older)*	No copay *(deductible waived)*	Not covered
➢ Adult preventive services *(including mammograms, Pap smears, prostate cancer screenings & colorectal cancer screenings)*	No copay *(deductible waived)*	40% *(deductible waived)*
Physical Therapy, Physical Medicine & Occupational Therapy	20%	40%
Chiropractic Services *(limited to 30 visits/calendar year)*[4]	$20/visit *(deductible waived)*	40%
Speech Therapy	20%	40%
Acupuncture		
➢ Services for the treatment of disease, illness or injury *(limited to 20 visits/calendar year)*	$20/visit *(deductible waived)*	40%[3]
Temporomandibular Joint Disorders		
➢ Splint therapy & surgical treatment	20%	40%
Pregnancy & Maternity Care		
➢ Physician office visits	$20/visit[2] *(deductible waived)*	40%
➢ Prescription drug for abortion *(mifepristone)*	20%	40%
Normal delivery, cesarean section, complications of pregnancy & abortion*)*		
➢ Inpatient physician services	20%	40%
➢ Hospital & ancillary services	20%	40%

[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] The dollar copay applies only to the visit itself. An additional 20% copay applies for any services performed in office (i.e., x-ray, lab, surgery), after any applicable deductible.

[3] 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.).

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

Covered Services	PPO: Per Insured Person Copay	Non-PPO: Per Insured Person Copay
Organ & Tissue Transplants *(subject to utilization review; specified transplants covered only when performed at Blue Distinction Centers for Specialty Care [BDCSC] for out of California)*		
➢ Inpatient services provided in connection with non-investigative organ or tissue transplants	$200/admission + 20%	Not covered
➢ Transplant travel expense for an authorized, specified transplant at *BDCSC* *(recipient & companion transportation limited to $10,000 per transplant)*	No copay *(deductible waived)*	Not covered
➢ Unrelated donor search, limited to $30,000 per transplant		
Bariatric Surgery *(subject to utilization review; medically necessary surgery for weight loss, only for morbid obesity, covered only when performed at Centers of Medical Excellence [CME*		
➢ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity	$200/admission + 20%	Not covered
➢ Bariatric travel expense when member's home is 50 miles or more from the nearest bariatric *CME (member's transportation to & from CME limited to $130/person/trip for 3 trips [pre-surgical visit, initial surgery & one follow-up visit]; one companion's transportation to & from CME limited to $130/person/trip for 2 trips [initial surgery & one follow-up visit]; hotel for member & one companion limited to one room double occupancy & $100/day for 2 days/trip, or as medically necessary, for pre-surgical & follow-up visit; hotel for one companion limited to one room double occupancy & $100/day for duration of member's initial surgery stay for 4 days; other reasonable expenses limited to $25/day/person for 4 days/trip)*	No copay *(deductible waived)*	Not covered
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/visit *(deductible waived)*	40%
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%	40%
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]	40%[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 deductible waived if admitted)*	20%	20%
➢ Inpatient hospital services & supplies	20%	20%
➢ Physician services	20%	20%

[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 40%. All copays are in addition to applicable deductibles.

Covered Services	PPO: Per Insured Person Copay	Non-PPO: Per Insured Person Copay
Mental or Nervous Disorders and Substance Abuse		
➢ Inpatient facility care *(subject to utilization review; waived for emergency admissions)*	$200/admission + 20%	40%[1]
➢ Inpatient physician visits	20%	40%
➢ Outpatient facility care	20%	40%[1]
➢ Physician office visits *(Behavioral Health treatment for Autism and Pervasive Development disorder requires pre-service review)*	$20/visit[2] *(for non-preventive visits; deductible does not apply)*	40% *(after medical deductible is met)*

[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] The dollar copay applies only to the visit itself. An additional 20% copay applies for any services performed in the office (i.e., X-ray, lab, surgery), after any applicable deductible.

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

This plan includes custom benefits that may supersede some of the information included in the Limitations and Exclusions link provided here. Please see your EOC for full details on your covered benefit