Loyola Marymount University/RSHM Custom Fee-For-Service Medical $500 Plan- Actives

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.

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. 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. It is the payment towards the services billed by a provider combined with any applicable deductible, copayment or coinsurance.

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 may be responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.

Calendar year deductible	$500/insured person; $1,000/family
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	$3,000/insured person/$6,000/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	Per Insured Person Copay
Hospital Medical Services *(subject to utilization review for inpatient services; waived for emergency admissions)*	
➢ Semi-private room, meals & special diets, & ancillary services	$200/admission + 20%
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	20%
Ambulatory Surgical Centers	
➢ Outpatient surgery, services & supplies	20%
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 or substance abuse)*	20%
Hospice Care	
➢ Inpatient or outpatient services *(inpatient, home hospice & bereavement counseling services; family bereavement counseling)*	20%
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; not covered while insured person receives hospice care)*	20%

Covered Services	Per Insured Person Copay
Physician Medical Services	
➢ Office & home visits	20%
➢ Hospital & skilled nursing facility visits	20%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	20%
Diagnostic X-ray & Lab	
➢ MRI, CT scan, PET scan & nuclear cardiac scan *(subject to utilization review)*	20%
➢ Other diagnostic x-ray & lab	20%
Radiation Therapy, Chemotherapy, and Hemodialysis Treatment	20%
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)*
Physical Therapy, Physical Medicine & Occupational Therapy	20%
Chiropractic Services *(limited to 30/visits calendar year)*[2]	20%
Speech Therapy	20%
Acupuncture	
➢ Services for the treatment of disease, illness or injury *(limited to 20 visits/calendar year)*	20%[1]
Temporomandibular Joint Disorders	
➢ Splint therapy & surgical treatment	20%
Pregnancy & Maternity Care	
➢ Physician office visits	20%
➢ Prescription drug for abortion *(mifepristone)*	20%
Normal delivery, cesarean section, abortion	
➢ Inpatient physician services	20%
➢ Hospital & ancillary services	20%
Organ & Tissue Transplants *(subject to utilization review)*	
➢ Inpatient services provided in connection with non-investigative organ or tissue transplants	$200/admission + 20%
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%
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%

[1] 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.).

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

Covered Services	Per Insured Person Copay
Durable Medical Equipment	
➢ Rental or purchase of DME including hearing aids, dialysis equipment & supplies *(hearing aids benefit is 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%
Related Outpatient Medical Services & Supplies	
➢ Ground or air ambulance transportation, services & disposable supplies	20%
➢ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	20%
➢ Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)*	20%
Emergency Care	
➢ Emergency room services & supplies *($100 deductible waived if admitted)*	20%
➢ Inpatient hospital services & supplies	20%
➢ Physician services	20%
Mental or Nervous Disorders and Substance Abuse	
➢ Inpatient facility care *(subject to utilization review; waived for emergency admissions)*	$200/admission + 20%
➢ Inpatient physician visits	20%
➢ Outpatient facility care	20%
➢ Physician office visits *(Behavioral Health Treatment for Autism and Pervasive Development disorders will be subject to pre-service review)*	20% *(for non-preventive visits after medical deductible is met)*

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_Fee For Service

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