Custom Premier PPO 500/20 30/20 Loyola Marymount University/RSHM 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.

In addition to dollar and percentage copays, members 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. Members 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, members 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 Providers & Other Health Care Providers	$500/member; $1,000/family
Non-PPO Providers	$750/member; $1,200/family
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center	$500/admission *(waived for emergency admission)*
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 *(no cross application)*	
PPO Providers & Other Health Care Providers	$2,500/member/year; $5,000/family/year
Non-PPO Providers	$5,000/member/year; $10,000/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 Member Copay**	**Non-PPO: Per Member Copay**
Hospital Medical Services *(subject to utilization review for inpatient services; waived for emergency admissions)*		
➢ Semi-private room, meals & special diets, & ancillary services	20%	40%[1]
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	20%	40%[1]
Ambulatory Surgical Centers		
➢ Outpatient surgery, services & supplies	20%	40% *(benefit limited to $350/day)*
Hemodialysis		
➢ Outpatient hemodialysis services & supplies	20%	40% *(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%	40%
Hospice Care		
➢ Inpatient or outpatient services; family bereavement services	20%[2]	

[1] For California facilities, a discount will be applied if the facility has a contract with Anthem Blue Cross for fee-for-service business. For California facilities without a contract, covered expense for hospital services and supplies is reduced by 25%, resulting in higher costs for members.

[2] These providers are not represented in the Anthem Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay
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 member receives hospice care)*	20%	40%
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%	40% *(benefit limited to $600/day)*
Physician Medical Services		
➢ Office & home visits *(includes retail health clinics and online visits)*	$20/visit[1] *(deductible waived)*	40%
➢ Specialists	$30/visit[1] *(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*	20%	40%
➢ *are subject to utilization review)*		
Diagnostic X-ray & Lab		
➢ MRI, CT scan, PET scan & nuclear cardiac scan *(subject to utilization review)*	20%	40%
➢ Other diagnostic x-ray & lab	20%	40%
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 examinations *(birth through age six)*	No copay *(deductible waived)*	40%
➢ Immunizations *(birth through age six)*	No copay *(deductible waived)*	40%
➢ 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%[2]
Temporomandibular Joint Disorders		
➢ Splint therapy & surgical treatment	20%	40%
Pregnancy & Maternity Care		
➢ Physician office visits	$20/visit[1] *(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%[3]

[1] 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.
[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.).
[3] For California facilities, a discount will be applied if the facility has a contract with Anthem Blue Cross for fee-for-service business. For California facilities without a contract, covered expense for hospital services and supplies is reduced by 25%, resulting in higher costs for members.
[4] Additional visits as authorized if medically necessary; pre-service review must be obtained prior to receiving the services.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay
Organ & Tissue Transplants *(subject to utilization review; specified organ transplants covered only when performed at Centers of Medical Excellence [CME])]; Blue Distinction Centers for Specialty Care [BDCSC] for out of California)*		
➢ Inpatient services provided in connection with non-investigative organ or tissue transplants	20%	Not covered
➢ Transplant travel expense for an authorized, specified transplant at *CME* *(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	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 members & 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 members with diabetes	20%	40%
Durable Medical Equipment		
➢ Rental or purchase of DME including hearing aids, dialysis equipment & supplies *(breast pump and supplies are covered under preventive care at no charge for in-network; hearing aids benefit is available for one hearing aid per ear every three years)*	20%	40%
Related Outpatient Medical Services & Supplies		
➢ Ground or air ambulance transportation, services & disposable supplies	20%[1]	
➢ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	20%[1]	
➢ Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)*	20%[1]	

[1] These providers are not represented in the Anthem Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay
Emergency Care		
➢ Emergency room services & supplies *($100 deductible 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%	40%[1]
➢ Inpatient physician visits	20%	40%
➢ Outpatient facility care	20%	40%[1]
➢ Physician office visits *(Behavioral Health treatment for Autism or Pervasive Development disorders requires pre-service review)*	$20/visit[2] *(deductible waived)*	40%

[1] For California facilities, a discount applies if the facility has a contract with Anthem Blue Cross for fee-for-service business. For California facilities without a contract, covered expense for non-emergency hospital services and supplies is reduced by 25%, resulting in higher out-of-pocket costs for members.

[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.

This Summary of Benefits is a brief review of benefits. Once enrolled, members will receive a Combined Evidence of Coverage and Disclosure Form, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.

Premier Plan Exclusions and Limitations

Not Medically Necessary. Services or supplies that are not medically necessary, as defined.

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 request an independent medical review, as described in the Evidence of Coverage (EOC).

Outside the United States. Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with urgent care or an emergency.

Crime or Nuclear Energy. Conditions that result from (1) the member's commission of or attempt 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) any release of nuclear energy, whether or not the result of war, when government funds are available for the treatment of illness or injury arising from the release of nuclear energy.

Not Covered. Services received before the member's effective date. Services received after the member's coverage ends, except as specified as covered in the EOC.

Excess Amounts. Any amounts in excess of covered expense or the lifetime maximum.

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, whether or not the member claims those benefits. If there is a dispute of substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, we will provide the benefits of this plan for such conditions, subject to a right of recovery and reimbursement under California Labor Code Section 4903, as specified as covered in the EOC.

Government Treatment. Any services the member actually received that were provided by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state 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 insured person for free.

Services of Relatives. Professional services received from a person living in the member's home or who is related to the member by blood or marriage, except as specified as covered in the EOC.

Voluntary Payment. Services for which the member has no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:

1. it must be internationally known as being devoted mainly to medical research;
2. at least 10% of its yearly budget must be spent on research not directly related to patient care;
3. at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. it must accept patients who are unable to pay; and
5. two-thirds of its patients must have conditions directly related to the hospital's research.

Not Specifically Listed. Services not specifically listed in the plan as covered services.

Private Contracts. Services or supplies provided pursuant to a private contract between the member and a provider, for which reimbursement under Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. Mental or nervous disorders and alcohol or drug dependence, including rehabilitative care in relation to these conditions, except as specified as covered in the EOC.

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental implants, dental services, extraction of teeth, treatment to the teeth or gums, or treatment to or for any disorders for the temporomandibular (jaw) joint, except as specified as covered in the EOC. Cosmetic dental surgery or other dental services for beautification.

Hearing Aids or Tests. Hearing aids and routine hearing tests, except as specified as covered in the EOC.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, eyeglasses or contact lenses, except as specified as covered in the EOC.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a home health agency, hospice, or infusion therapy provider, except as specified as covered in the EOC.

Outpatient Speech Therapy. Outpatient speech therapy, except as specified as covered in the EOC.

Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.

Commercial Weight Loss Programs. Weight loss programs, whether or not they are pursued under medical or *physician* 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 dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as described in the Evidence of Coverage (EOC).

Sterilization Reversal.

Infertility Treatment. Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal and gamete intrafallopian transfer.

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).

Orthopedic Supplies. Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient, or therapeutic shoes and inserts designed to treat foot complications due to diabetes, as specifically stated in the Certificate

Air Conditioners. Air purifiers, air conditioners or humidifiers.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility or custodial care or rest cures, except as specified as covered in the EOC.

Health Club Memberships. 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 *physician*. This exclusion also applies to health spas.

Personal Items. Any supplies for comfort, hygiene or beautification.

Education or Counseling. Educational services or nutritional counseling, except as specified as covered in the EOC. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.

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 requirement either a written prescription or dispensing by a licensed pharmacist.

Telephone and Facsimile Machine Consultations. Consultations provided by telephone or facsimile machine.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specified as covered in the EOC.

Acupuncture. Acupuncture treatment, as specified as covered in the EOC. Acupressure or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Physical Therapy or Physical Medicine. Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement or as specified as covered in the EOC.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specified as covered in the EOC. Any non-prescription, over-the-counter patent or proprietary drug or medicine. Cosmetics, health or beauty aids.

Specialty Pharmacy Drugs. 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 should have been obtained from the specialty pharmacy program.**

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specified as covered in the EOC.

Diabetic Supplies. Prescription and non-prescription diabetic supplies except as specified as covered in the EOC.

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse.

Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by us.

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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.