



MEBA MOD POS Plan High Option \$20/20/40

POS Benefits

For HMO, all services must be authorized by the primary care physician (PCP) and/or the medical group, except services provided under the "ReadyAccess" program, OB/GYN services received within the member's medical group/IPA, and services for all mental disorders. PPO & non-PPO benefits will not be paid for services provided by the member's PCP, or for ReadyAccess program services provided by a physician who works with the member's medical group.

For PPO & non-PPO, in addition to the per member copays, there may be a deductible. Please review the deductible information below 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. Regardless from whom they receive services, members are also responsible for all costs over the plan maximums. Plan maximums & other important information appear in *italics*. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Explanation of Covered Expense

HMO—Charges incurred for covered services received from or authorized by the member's PCP or medical group, not to exceed the negotiated rate for some services.

Anthem Blue Cross PPO Providers—Plan payments are based on covered expense which is the lesser of either the charges billed by the provider or the Anthem Blue Cross PPO negotiated rate or fee. Members are not responsible for the difference between the providers usual charges & the negotiated amount.

Non-PPO & Other Health Care Providers (*includes those not represented in the Anthem Blue Cross PPO provider network*)—The customary & reasonable charge for professional services or the reasonable charge for institutional services.

When using Non-PPO & Other Health Care Providers, members are responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copays.

	HMO	Providers PPO	Non-PPO
Calendar year deductible for PPO/non-PPO providers	N/A	\$300/member; \$600/family	
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center (<i>waived for emergency admission</i>)	N/A	N/A	\$500/admission
Annual out-of-pocket maximums (<i>HMO & PPO/non-PPO</i>)	\$1,000/member	\$2,500/member	
\$5,000/member			
<i>out-of-pocket maximums are exclusive of each other</i>	\$2,000/family	\$5,000/family	\$10,000/family
For HMO services —percentage copay for infertility services & non-covered expense are not applied to the out-of-pocket maximum.			
For PPO & Non-PPO services —deductibles listed above, percentage copays for family planning (counseling & visit), sterilization for males & females, & non-covered expense are not applied to the out-of-pocket maximum. After a member reaches out-of-pocket maximum, the member remains responsible for percentage copays for family planning services (counseling & visit), sterilization for males & females, and, for non-PPO & other health care providers' services, costs in excess of the covered expense/ amounts related to a transplant unrelated donor search.			
Lifetime Maximum	N/A		N/A
Covered Services	HMO: Per Member Copay	PPO: Per Member Copay	Non-PPO: Per Member Copay
Hospital Medical Services (<i>subject to utilization review for inpatient services at PPO & non-PPO facilities; waived for emergency admissions</i>)			
➤ Semi-private room, meals, special diets & ancillary services	No copay	20%	40% ¹
➤ Outpatient medical care (<i>hospital care other than emergency room services</i>)	No copay	20%	40% ¹
Ambulatory Surgical Center (<i>subject to utilization review for services at PPO & non-PPO facilities; waived for emergency admissions</i>)			
➤ Outpatient surgery, services & supplies	No copay	20%	40%
Hemodialysis			
➤ Outpatient hemodialysis services & supplies	No Copay	20%	40%
Skilled Nursing Facility (<i>PPO & non-PPO providers' services will not be covered if utilization review not obtained; limited to 100 days/calendar year, including residential treatment centers</i>)			
➤ Semi-private room & necessary services & supplies (<i>excludes take-home drugs</i>)	No copay	20%	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.

Covered Services	HMO: Per Member Copay	PPO: Per Member Copay	Non-PPO: Per Member Copay
Hospice Care			
➤ (Inpatient or outpatient services for members; family bereavement services)	No copay	20% ¹	20% ¹
Home Health Care (PPO & non-PPO providers' services will not be covered if utilization review not obtained; limited to 100 visits/calendar year; one visit by home health aide equals four hours or less)			
	No copay	20%	40%
Physician Medical Services			
➤ Office & home visits	\$20/visit	20%	40%
➤ Hospital & skilled nursing facility visits	No copay	20%	40%
➤ Surgeon & surgical assistant; anesthesiologist or anesthesiologist	No copay	20%	40%
➤ Specialists & consultants	\$30/visit	20%	40%
➤ Short-term physical therapy, physical medicine, occupational therapy & chiropractic care (limited to a combined HMO, PPO & non-PPO 60-day period of care after an illness or injury; an additional period of care may be authorized)	\$30/visit	20%	40%
➤ Speech therapy following surgery or when due to an injury or organic disease	No copay	20%	40%
➤ Acupuncture services for the treatment of disease, illness or injury (benefit limited to \$30/visit & 12 visits/calendar year)	Not covered	20% ²	40% ²
General Medical Services			
➤ Diagnostic X-ray & laboratory procedures (excluding X-ray & lab services performed for a routine exam)			
— MRI, CT scan, PET scan & nuclear cardiac scan (PPO & non-PPO providers' services will not be covered if utilization review not obtained)	No copay	20%	40%
— Other diagnostic x-ray & lab	No copay	20%	40%
➤ Radiation therapy & chemotherapy	No copay	20%	40%
➤ Prosthetic devices	No copay	20%	40%
➤ Durable Medical Equipment including hearing aids	No copay	20%	40%
Organ & Tissue Transplants (subject to utilization review)			
➤ Inpatient services provided in connection with non-investigative organ or tissue transplants	No copay	20% (specified organ transplants covered only at Centers of Medical Excellence [CME])	
➤ Physician office visits (including specialists & consultants)	\$30/visit	20%	Not covered
➤ Transplant travel expense for an authorized, specified transplant at Centers of Medical Excellence [CME] (recipient & companion transportation limited to 6 trips/episode & \$250/person/trip for round-trip coach airfare, hotel limited to 1 room double occupancy/\$100/day for 21 days/trip; donor transportation limited to 1 trip/episode & \$250 for round-trip coach airfare, hotel limited to \$100/day for 7 days)	Not covered	No copay (deductible waived)	Not covered
Bariatric Surgery (subject to utilization review)			
➤ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity	No copay	20% (bariatric surgery covered only at Centers of Medical Excellence [CME])	
➤ Physician office visits (including specialists & consultants)	\$30/visit	20%	Not covered
➤ Bariatric travel expense when member's home is 50 miles or more from the nearest Bariatric Centers of Medical Excellence (member's transportation to & from COE limited to \$130/trip for 3 trips [pre-surgical visit, initial surgery & one follow-up visit]; one companion's transportation to & from COE limited to \$130/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)	Not covered	No copay (deductible waived)	Not covered

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

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	HMO: Per Member Copay	PPO: Per Member Copay	Non-PPO: Per Member Copay
Autologous blood (self-donated blood collection, testing, processing & storage)	No copay	20% ¹	40% ¹
Injections & injected substances (including allergy serum & medication)	No copay	20%	40%
Preventive Care			
➤ Routine physical exams performed by a physician	No copay	No copay (deductible waived)	40%
➤ Routine gynecological exams for females, including Pap smears & mammograms	No copay	No copay (deductible waived)	40%
➤ Prostate cancer screenings	No copay	No copay (deductible waived)	40%
➤ Diagnostic X-ray & lab for routine physical exam	No copay	No copay (deductible waived)	40%
➤ Well-baby & well-child care	No copay	No copay (deductible waived)	40%
➤ Hearing exams	\$30/visit	Not covered	Not covered
➤ Specified immunizations	No copay	No copay (deductible waived)	Not covered
➤ Allergy testing & treatment (including serums)	\$30/visit	20%	40%
Vision Exams			
➤ Vision screening to determine medical necessity of vision exam; evaluation with initiation of diagnostic & treatment programs & refractions if authorized by the PCP	\$30/visit	Not covered	Not covered
Health Education & Wellness Programs			
➤ Instruction in health maintenance & wellness	No copay	20%	40%
➤ Health education programs (as announced)	Possible charge	Not covered	Not covered
Emergency Care			
➤ Physician & medical services	No copay	20%	40%
➤ Outpatient hospital emergency room services (copay waived if admitted)	\$75/visit	\$75/visit	\$75/visit
➤ Inpatient hospital services (for PPO 20%, and non-PPO 40% after the first 48 hours, unless the member cannot be moved safely)	No copay	20%	40%
Ambulance			
➤ Ground or air ambulance transportation when medically necessary, including medical services & supplies	No copay	20% ¹	20% ¹
Pregnancy & Maternity Care			
➤ Physician office visits Normal delivery, cesarean section, complications of pregnancy & therapeutic abortion	\$20/visit	20%	40%
➤ Inpatient physician services	No copay	20%	40%
➤ Alternative birthing centers	No copay	20%	40%
➤ Hospital & ancillary services	No copay	20%	40% ²
Elective abortion (including prescription drug for abortion [mifepristone])	\$150	20%	40%
Genetic testing of fetus	No copay	20%	40%
Family planning services			
➤ Infertility studies & tests	50% ⁴	Not covered	Not covered
➤ Tubal ligation	\$150	50% ⁴	50% ⁴
➤ Vasectomy	\$75	50% ⁴	50% ⁴
➤ Counseling & consultation	\$30/visit	50% ⁴	50% ⁴

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

² 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.

³ The member's percentage copay is not applicable to the annual out-of-pocket maximum.

Covered Services	HMO: Per Member Copay	PPO: Per Member Copay	Non-PPO: Per Member Copay
Mental Disorders and Substance Abuse			
Inpatient Care			
➤ Facility-based care (subject to utilization review for PPO & non-PPO facilities; waived for emergency admissions)	No copay	20%	40% ¹
➤ Inpatient physician visits	No copay	20%	40% ¹
Outpatient Care			
➤ Facility-based care (subject to utilization review for PPO & non-PPO facilities; waived for emergency admissions)	No copay	20%	40% ¹
➤ Physician outpatient visits (pre-service review required after the 12th visit)	\$30/visit	20%	40% ¹

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.

This is a brief summary of benefits. For complete information, including the terms and conditions of this plan and the complete exclusions and limitations, please refer to the Evidence of Coverage and Disclosure Form.

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POS — Exclusions and Limitations

Medical care not covered under HMO benefits:

Not Authorized. Any services not authorized by the member's primary care physician or medical group, except for emergency services and urgent care and as otherwise specified as covered in the Evidence of Coverage (EOC).

Services Provided by Non-Participating Providers. Any services provided by a non-participating provider, except for authorized referrals, emergency services or urgent care as specified as covered in the EOC.

Optometric Services or Supplies. Optometric services, eye exercises and orthoptics, except for eye examinations to determine the need for vision correction. Eyeglasses or contact lenses, except as specified as covered in the EOC. Contact lens fitting.

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 will be covered only when criteria is met as recommended by our Medical Policy.

Surrogacy. Any services or supplies provided in connection with a surrogate pregnancy, i.e., the bearing of a child by another woman for an infertile couple, unless the surrogate mother is an enrolled Anthem Blue Cross POS member.

Sexual Dysfunction. Treatment of any sexual dysfunction, except as specified as covered in the EOC.

Routine Examinations. Routine physical or psychological examinations or tests required by employment or government authority, or at the request of a third party such as a school, camp or sport affiliated organization. Any other routine physical or psychological examination or test which does not directly treat an actual illness, injury or condition, except as specified as covered in the EOC.

Immunizations. Immunizations for foreign travel. Immunizations, except as specified as covered in the EOC.

Acupuncture. Acupuncture, 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.

Medical care not covered under Opt-out Benefits

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 emergency care.

Excess Amounts. Any amounts in excess of covered expense or the opt-out medical benefit maximums.

HMO Benefits. Services or supplies for which any benefits are authorized, provided and received under the HMO benefits of the plan, including any authorized services received for the treatment of an emergency. Services and supplies provided by the member's primary care physician or services provided through the ReadyAccess Program.

Excluded under HMO. Services or supplies which are excluded under the HMO benefits of the plan, except to the extent that the services of a provider who is not a participating provider in the Anthem Blue Cross POS network are payable under the opt-out benefits of the plan.

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

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.

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 home infusion therapy provider as specified as covered in the EOC.

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).

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

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.

Any other routine physical examination or test which does not directly treat an actual illness, injury or condition, except as specified as covered in the EOC.

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.**

Medical care not covered under HMO and Opt-out Benefits

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 EOC.

Crime or Nuclear Energy. Conditions that result from (1) the member's commission 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.

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, even if the member does not claim 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 member for free.

Voluntary Payment. Services for which the member is not legally obligated to pay. Services for which the member is not charged. Services for which no charge is made in the absence of insurance 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.

Mental Disorders. Academic or educational testing, counseling, and remediation. Mental disorders or chemical dependency, including rehabilitative care in relation to these conditions, except as specified as covered in the EOC.

Nicotine Use. Smoking cessation programs or treatment of nicotine or tobacco use.

Smoking cessation drugs.

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 or treatment to the teeth or gums, except as specified as covered in the EOC. Cosmetic dental surgery or other dental services for beautification.

Hearing Aids or Tests. Hearing aids or services related to the fitting or making of a hearing aid, except as specified as covered in EOC for hearing exams under the HMO benefits and hearing aid services as specified as covered in EOC for opt-out benefits.

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

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

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.

Sex Transformation. Procedures or treatments to change characteristics of the body to those of the opposite sex.

Sterilization Reversal.

Infertility Treatment. Artificial insemination or in vitro fertilization procedures and any related laboratory procedures. Infertility treatment, family planning or birth control services, except as specified as covered in the EOC.

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 supplies, orthopedic shoes (other than shoes joined to braces), or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications as specified as covered in the EOC.

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. Custodial care or rest cures, except as specified as covered in the EOC. 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, custodial care or rest cures, except as specified as covered in the EOC.

Chronic Pain. Treatment of chronic pain, 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.

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

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.

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.

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.

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 the member's medical group or, under the opt-out benefits, approved by us.

Clinical Trials. Services and supplies in connection clinical trials, except as specified as covered in the EOC.

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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