



City of Merced Low Option Plan

EPO Benefits

This Summary of Benefits is a brief overview of your plan's benefits only. For more detailed information about the benefits in your plan, please refer to your Certificate of Insurance or Evidence of Coverage (EOC), which explains the full range of covered services, as well as any exclusions and limitations for your plan.

Anthem Blue Cross EPO members must receive health care services from Anthem Blue Cross PPO (Prudent Buyer) network providers, unless they receive authorized referrals or need emergency and/or out-of-area urgent care. Emergency services received from a Non-PPO hospital and without an authorized referral are covered only for the first 48 hours. Coverage will continue beyond 48 hours if the member can't be moved safely.

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. 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.

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	\$100/member; \$300/family (<i>aggregate</i>)
Deductible for emergency room services	\$200/visit (<i>waived if admitted directly from ER</i>)
Annual Copay/Coinsurance Maximum	\$1,600/member/year \$3,300/family/year

The following do not apply to out-of-pocket maximums: non-covered expenses. After the annual copay 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.

Copays and Deductibles are waived for members with Medicare as primary payor.

Lifetime Maximum	Unlimited
Covered Services	PPO: Per Member Copay¹
Hospital Medical Services (<i>subject to utilization review for inpatient services; waived for emergency admissions</i>)	
➤ Semi-private room, meals & special diets, & ancillary services	\$100/day 1 st three days/per occurrence
➤ Outpatient medical care & supplies (<i>hospital care other than emergency room care</i>)	No copay
➤ Outpatient Surgery	\$100/occurrence
Ambulatory Surgical Centers (<i>subject to utilization review for inpatient services; waived for emergency admissions</i>)	
➤ Outpatient surgery, services & supplies	\$100/occurrence
Skilled Nursing Facility (<i>subject to utilization review</i>)	
➤ Semi-private room, services & supplies (<i>limited to 100 days/calendar year; limit does not apply to mental health and substance abuse</i>)	No copay
Hospice Care	
➤ Inpatient or outpatient services for members with up to one year life expectancy; family bereavement services	No copay ²
Home Health Care (<i>subject to utilization review</i>)	
➤ Services & supplies from a home health agency (<i>limited to 100 visits/calendar year, one visit by home health aide equals four hours or less; not covered while member receives hospice care</i>)	\$20/visit

¹ Non-emergency services from non-PPO providers are covered only with an authorized referral.

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

Covered Services	PPO: Per Member Copay ¹
Home Infusion Therapy <i>(subject to utilization review)</i>	
➤ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	No copay
Physician Medical Services	
➤ Office Visits	\$20/visit <i>(deductible waived)</i>
➤ Home Visits	\$25/visit <i>(deductible waived)</i>
➤ Hospital & skilled nursing facility visits	No copay
➤ Surgeon & surgical assistant; anesthesiologist or anesthesiologist	No copay
➤ Internet based consultations	\$20 per consultation <i>(deductible waived)</i>
➤ Non contraceptive injections in Physicians office	No copay
Diagnostic X-ray & Lab	No copay
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.	No copay <i>(deductible waived)</i>
*This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.	
Physical Therapy, Physical Medicine & Occupational Therapy <i>(Benefits provided, with submission of a treatment plan, as long as treatment is deemed medically necessary)</i>	\$20/visit
Chiropractic Services <i>(limited to 30 visits/calendar year)</i>	\$5/visit
Speech Therapy	
➤ Outpatient speech therapy following injury or organic disease <i>(Benefits provided, with submission of treatment plan, as long as treatment is deemed medically necessary)</i>	\$20/visit
Temporomandibular Joint Disorders	
➤ Splint therapy & surgical treatment	\$20/visit
Pregnancy & Maternity Care	
➤ Physician office visits	No copay <i>(deductible waived)</i>
Normal delivery, cesarean section, complications of pregnancy & abortion	
➤ Inpatient physician services	No copay <i>(deductible waived)</i>
➤ Hospital & ancillary services	No copay <i>(deductible waived)</i>
➤ Outpatient routine newborn circumcision	\$20/visit <i>(in the office)</i> No copay <i>(in outpatient facility)</i>
Family Planning and Infertility Services	
➤ Family planning counseling	\$20/visit <i>(deductible waived)</i>
➤ Contraceptive Injections	\$25/injection plus office visit copay
➤ Diagnosis and treatment of cause of infertility	50% of allowed charges
➤ Elective abortion <i>(professional services in office or outpatient hospital facility)</i>	\$100 (per event)
➤ Female Sterilization <i>(including tubal ligation and counseling/consultation)</i>	No copay
➤ Male Sterilization	\$75 copay

¹ Non-emergency services from non-PPO providers are covered only with an authorized referral.

Covered Services	PPO: Per Member Copay ¹
Organ & Tissue Transplants <i>(subject to utilization review; specified organ transplants covered only when performed at a Center of Expertise [COE])</i> <ul style="list-style-type: none"> ➤ Inpatient services provided in connection with non-investigative organ or tissue transplants ➤ Physician office visits ➤ Transplant travel expense for an authorized, specified transplant at a COE <i>(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, other expenses limited to \$25/day/person 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, other expenses limited to \$25/day for 7 days)</i> 	\$100/day 1 st three days/per occurrence \$20/visit <i>(deductible waived)</i> No copay
Bariatric Surgery <i>(subject to utilization review; medically necessary surgery for weight loss, only for morbid obesity, covered only when performed at a Center of Expertise [COE])</i> <ul style="list-style-type: none"> ➤ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity ➤ Physician office visits 	\$100/day 1 st three days/per occurrence \$20/visit <i>(deductible waived)</i>
Diabetes Education Programs <i>(requires physician supervision)</i> <ul style="list-style-type: none"> ➤ Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training 	\$20/visit <i>(deductible waived)</i>
Prosthetic Devices or Orthotic Devices <ul style="list-style-type: none"> ➤ 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 ➤ Surgically implanted devices or supplies 	20% No copay
Durable Medical Equipment <ul style="list-style-type: none"> ➤ Rental or purchase of DME including dialysis equipment & supplies 	20%
Related Outpatient Medical Services & Supplies <ul style="list-style-type: none"> ➤ Ground or air ambulance transportation, services & disposable supplies ➤ Blood transfusions, blood processing & the cost of unreplaced blood & blood products ➤ Autologous blood <i>(self-donated blood collection, testing, processing & storage for planned surgery)</i> 	\$50 copay ² No copay ² No copay ²
Emergency Care <ul style="list-style-type: none"> ➤ Emergency room services & supplies <i>(\$200 deductible waived if admitted)</i> ➤ Inpatient hospital services & supplies ➤ Physician services 	No copay No copay No copay
Mental or Nervous Disorders and Substance Abuse <ul style="list-style-type: none"> ➤ Inpatient facility care <i>(subject to utilization review; waived for emergency admissions)</i> ➤ Inpatient physician visits ➤ Outpatient facility-based care ➤ Physician office visits <i>(Behavioral Health treatment for Autism or Pervasive Development disorders requires pre-service review)</i> 	\$100/day 1 st three days/per occurrence No copay No copay \$20/visit for non-preventive visits <i>(deductible waived)</i>

¹ Services from non-PPO providers are covered only with an authorized referral.

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

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.

EPO—Prudent Buyer Exclusive 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 Certificate.

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 Certificate.

Excess Amounts. Any amounts in excess of covered expense or any medical benefit 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 Certificate.

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.

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 Certificate.

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 or substance abuse, including rehabilitative care in relation to these conditions, except as specified as covered in the Certificate.

Nicotine Use. Smoking cessation programs or treatment of nicotine or tobacco use if the program is not affiliated with Anthem. Smoking cessation drugs except as specified as covered in the EOC or Certificate.

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

Dental Services or Supplies. For dental treatment, regardless of origin or cause, except as specified below. "Dental treatment" includes but is not limited to preventative care and fluoride treatments; dental x rays, supplies, appliances, dental implants and all associated expenses; diagnosis and treatment related to the teeth, jawbones or gums, including but not limited to:

1. Extraction, restoration, and replacement of teeth; 2. Services to improve dental clinical outcomes.

This exclusion does not apply to the following:

1. Services which we are required by law to cover; 2. Services specified as covered in this booklet; 3. Dental services to prepare the mouth for radiation therapy to treat head and/or neck cancer.

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

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

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

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

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 Certificate.

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, except as specified as covered in the Certificate.

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 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 EOC/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 Certificate.

Clinical Trials - Services and supplies in connection with clinical trials, except as specified as covered in the Certificate or 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, except as specified as covered in the Certificate.

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

Education or Counseling. Educational services or nutritional counseling, except as specified as covered in the Certificate. 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.

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 Certificate.

Acupuncture. Acupuncture treatment, except as specified as covered in the Certificate. 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 Eye glasses 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 Certificate.

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