City of Merced High 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.

Explanation of Covered Expense

Plan payments are based on covered expense, which is the lesser of the charges billed by the provider or the following:

PPO Providers—PPO negotiated rates. Members are not responsible for the difference between the provider's usual charges & the negotiated amount.

Non-PPO Providers *(services covered only with an authorized referral)* & Other Health Care Providers *(includes those not represented in the PPO provider network)*—The maximum allowable charge.

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	None
Deductible for emergency room services	$100/visit *(waived if admitted directly from ER)*
Annual Copay/Coinsurance Maximum	$1,000/member/year $2,000/family/year

The following copays do not apply to the annual copay maximum: non-covered expense. After a member reaches the copay maximum, the member no longer pays copays for the remainder of the year. However, member remains responsible for costs in excess of the covered expense.

Office visit copays are waived for members with Medicare as primary payor

Lifetime Maximum	Unlimited

Covered Services	PPO: Per Member Copay[1]
Hospital Medical Services *(subject to utilization review for inpatient services; waived for emergency admissions)*	
➢ Semi-private room, meals & special diets, & ancillary services	No copay
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	No copay
Ambulatory Surgical Centers	
➢ Outpatient surgery, services & supplies	No copay
Skilled Nursing Facility *(subject to utilization review)*	
➢ Semi-private room, services & supplies *(medical conditions & severe mental disorders limited to 100 days/calendar year)*	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 *(subject to utilization review)*	
➢ Services & supplies from a home health agency *(limited to 100 visits/calendar year, one visit by home health aide equals four hours or less; not covered while member receives hospice care)*	No copay

[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 *(subject to utilization review)*	
➢ 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	$10/visit
➢ Home Visits	$25/visits
➢ Hospital & skilled nursing facility visits	No copay
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	No copay
➢ Internet based consultations	$10 per consultation
➢ Non contraceptive injections in Physicians office	No copay
Diagnostic X-ray & Lab	No copay
Preventive Care Services *Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.*	
➢ Routine physical examinations *(birth through age six)*	No copay/exam *(deductible waived)*
➢ Immunizations *(birth through age six)*	No copay *(deductible waived)*
➢ Routine physical exams, immunizations, diagnostic X-ray & lab for routine physical exam *(members 7 years old and older)*	No copay/exam *(deductible waived)*
➢ Adult preventive services *(including mammograms, Pap smears, prostate cancer screenings & colorectal cancer screenings)*	No copay *(deductible waived)*
Physical Therapy, Physical Medicine & Occupational Therapy *(Benefits provided, with submission of a treatment plan, as long as treatment is deemed medically necessary)*	$10/visit
Chiropractic Services *(limited to 30 visits/calendar year)*	$5/visit
Speech Therapy	
➢ Outpatient speech therapy following injury or organic disease *(Benefits provided, with submission of treatment plan, as long as treatment is deemed medically necessary)*	$10/visit
Temporomandibular Joint Disorders	
➢ Splint therapy & surgical treatment	$10/visit
Pregnancy & Maternity Care *(services cover subscriber, spouse & dependent daughters)*	
➢ Physician office visits	No copay
Normal delivery, cesarean section, complications of pregnancy & abortion *(newborn routine nursery care covered when natural mother is subscriber or spouse/domestic partner)*	
➢ Inpatient physician services	No copay
➢ Hospital & ancillary services	No copay
➢ Outpatient routine newborn circumcision	$10/visit *(in the office)* No copay *(in outpatient facility)*
Family Planning and Infertility Services	
➢ Family planning counseling	$10/visit
➢ Contraceptive Injections	$25/injection plus office visit copay
➢ Diagnosis and treatment of cause of infertility	50% of allowed charges
➢ Elective abortion *(professional services in office or outpatient hospital facility)*	$100 (per event)
➢ Tubal Ligation *(copay waived if in conjunction with delivery or abdominal surgery)*	$100 copay
➢ Vasectomy	$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 *(subject to utilization review; specified organ transplants covered only when performed at a Center of Expertise [COE])*	
➢ Inpatient services provided in connection with non-investigative organ or tissue transplants	$100/day 1st three days
➢ Physician office visits	$10/visit
➢ Transplant travel expense for an authorized, specified transplant at a COE *(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)*	No copay
Bariatric Surgery *(subject to utilization review; medically necessary surgery for weight loss, only for morbid obesity, covered only when performed at a Center of Expertise [COE])*	
➢ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity	$100/day 1st three days
➢ Physician office visits	$10/visit
Diabetes Education Programs *(requires physician supervision)*	
➢ Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	$10/visit
Prosthetic Devices or Orthotic 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	50%
➢ Surgically implanted devices or supplies	No copay
Durable Medical Equipment	
➢ Rental or purchase of DME including dialysis equipment & supplies	50%
Related Outpatient Medical Services & Supplies	
➢ Ground or air ambulance transportation, services & disposable supplies	$50 copay[2]
➢ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	No copay[2]
➢ Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)*	No copay[2]
Emergency Care	
➢ Emergency room services & supplies *($100 deductible waived if admitted)*	No copay
➢ Inpatient hospital services & supplies	No copay
➢ Physician services	No copay
Mental or Nervous Disorders and Substance Abuse	
Inpatient Care	
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	No copay
➢ Inpatient physician visits	No copay
Outpatient Care	
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	No copay
➢ Outpatient physician visits	$10/visit *(deductible waived)*

[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

Non-Participating Providers. Services or supplies that are provided by a non-participating provider without an authorized referral, except emergency services or urgent care services.

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 or substance abuse, 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, 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.

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

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.

Weight Alteration Programs (Inpatient and Outpatient). Weight loss or weight gain programs including, but not limited to, dietary evaluations and counseling, exercise programs, behavioral modification programs, surgery, laboratory tests, food and food supplements, vitamins and other nutritional supplements associated with weight loss or weight gain. Dietary evaluations and counseling, and behavioral modification programs are covered for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered, except as specified as covered in the EOC.

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

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.

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 feet 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. 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.

Chronic Pain. Treatment of chronic pain, except as specified as covered in the EOC.

Exercise Equipment. Exercise equipment or any charges for activities, instrumentalities or facilities normally intended or used for developing or maintaining physical fitness including, but not limited to, charges from a physical fitness instructor, or health club or gym, even if ordered by a physician.

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. Food or dietary supplements, except as specified as covered in the EOC.

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. 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.

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.