County of Tehama EPO 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.

Blue Cross EPO members must receive health care services from 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	$500/member $1,500/family
Deductible for emergency room services	$100/visit *(waived if admitted directly from ER)*
Annual Out-of-Pocket Maximums	$3,000/member; $9,000/family

The following does not apply to maximums; deductibles listed above; percentage copays; dollars copays; non-covered expense. After a member pays $3,000/year in covered expense, the member will no longer be required to pay a percentage copay for the rest of the year. The member, however, remains responsible for dollar copays and non-covered expense.

Lifetime Maximum	Unlimited

Covered Services	**PPO: Per Member Copay[1]**
Hospital Medical Services *(preauthorization required for for inpatient services; waived for emergency admissions)*	
➢ Semi-private room, meals & special diets, & ancillary services	10%
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	10%
Ambulatory Surgical Centers *(preauthorization required, waived for emergency admissions)*	
➢ Outpatient surgery, services & supplies	10%
Skilled Nursing Facility *(preauthorization required)*	
➢ Semi-private room, services & supplies *(limited to 100 days/calendar year; limit does not apply to mental health and substance abuse)*	10%
Hospice Care	
➢ Inpatient or outpatient services for members with up to one year life expectancy; family bereavement services	10%[2]
Home Health Care *(preauthorization required)*	
➢ 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)*	10%

[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 *(preauthorization required)*	
➢ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	10%
Physician Medical Services	
➢ Office & home visits *(includes retail health clinic and online visits)*	$15/visit[3] *(deductible waived)*
➢ Hospital & skilled nursing facility visits	10%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	10%
Diagnostic X-ray & Lab	10%
Preventive Care	
➢ Routine physical examinations *(all ages)*	$25/exam *(deductible waived)*
➢ Immunizations *(all ages)*	No copay *(deductible waived)*
Preventive X-ray & Lab Services *(including mammograms, Pap smears, & prostate cancer screenings)*	10%
Physical Therapy, Physical Medicine & Occupational Therapy, including Chiropractic Services *(limited to 24 visits/calendar year; additional visits may be authorized)*	10%
Speech Therapy	
➢ Outpatient speech therapy following injury or organic disease	10%
Acupuncture	
➢ Services for the treatment of disease, illness or injury *(limited to 12 visits/calendar year)*	10%[2]
Temporomandibular Joint Disorders	
➢ Splint therapy & surgical treatment	10%
Pregnancy & Maternity Care	
➢ Physician office visits	$15/visit[3] *(deductible waived)*
➢ Prescription drug for elective abortion *(mifepristone)*	10%
Normal delivery, cesarean section, complications of pregnancy & abortion	
➢ Inpatient physician services	10%
➢ Hospital & ancillary services	10%

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

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 The dollar copay applies only to the visit itself. An additional 10% copay applies for any services performed in office (i.e., X-ray, lab, surgery).

Covered Services	PPO: Per Member Copay[1]
Organ & Tissue Transplants *(preauthorization required; 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	10%
➢ Physician office visits (*including specialties and consultants)*	$15/visit[3] *(deductible waived)*
➢ 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 *(deductible waived)*
Bariatric Surgery *(preauthorization required; 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	10%
➢ Physician office visits *(including specialists and consults)*	$15/visit[3] *(deductible waived)*
Diabetes Education Programs *(requires physician supervision)*	
➢ Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	$15/visit *(deductible waived)*
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.	10%
Durable Medical Equipment	
➢ Rental or purchase of DME including hearing aids, dialysis equipment & supplies, & therapeutic shoe & inserts for members with diabetes	10%
Related Outpatient Medical Services & Supplies	
➢ Ground or air ambulance transportation, services & disposable supplies	10%[2]
➢ Blood transfusions, blood processing & the cost unreplaced blood & blood products	10%[2]
➢ Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)*	10%[2]
Emergency Care	
➢ Emergency room services & supplies (*$100 deductible waived if admitted)*	10%
➢ Inpatient hospital services & supplies	10%
➢ Physician services	10%
Mental or Nervous Disorders and Substance Abuse	
➢ Inpatient facility care *(subject to utilization review; waived for emergency admissions)*	10%
➢ Inpatient physician visits	10%
➢ Outpatient facility care	10%
➢ Physician office visits	$15/visit[3] *(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.

[3] The dollar copay applies only to the visit itself. An additional 10% copay applies for any services performed in office (i.e., X-ray, lab, surgery).

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.

Anthem believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections of the Affordable Care Act apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Anthem at the telephone number printed on the back of your member identification card, or contact your group benefits administrator if you do not have an identification card. For ERISA plans, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1–866–444–3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For non-federal governmental plans, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

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. Any injury, condition or disease arising out of employment for which benefits or payments are covered by any worker's compensation law or similar law. If we provide benefits for such injuries, conditions or diseases we shall be entitled to establish a lien or other recovery under section 4903 of the California Labor Code or any other applicable law, as specified in the EOC/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 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.

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.

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, 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.

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.

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, except 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 Certificate. 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.

Medicare. For which benefits are payable under Medicare Parts A and/or B, or would have been payable if you had applied for Parts A and/or B, except as listed or as required by federal law, as described in the EOC. If you do not enroll in Medicare Part B, we will calculate benefits as if you had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large out of pocket costs.

Residential accommodations. Residential accommodations to treat medical or behavioral health conditions, except when provided in a hospital, hospice, skilled nursing facility or residential treatment center. This exclusion includes procedures, equipment, services, supplies or charges for the following:

- Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, custodial care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.