# County of Tehama PPO Plan

PPO Benefits

This Summary of Benefits is a brief overview of your plan's benefits only. The benefits listed are for both in state and out of state members, there may be differences in benefits depending on where you reside. 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.

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.**

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| **Calendar year deductible for all providers** | $250/member; $750/family |
| **Deductible for non-Blue Cross PPO hospital or residential treatment center** | $500/admission *(waived for emergency admission)* |
| **Deductible for non-Blue Cross PPO hospital, residential treatment center or ambulatory surgical center if services not preauthorized** | $500/admission *(waived for emergency admission)* |
| **Deductible for emergency room services** | $100/visit *(waived if admitted directly from ER)* |
| **Annual Out-of-Pocket Maximums** *(no cross application)* | |
| PPO Providers & Other Health Care Providers | $1,000/member/year |
| Non-PPO Providers | $2,000/member/year |

The following do not apply to out-of-pocket maximums: non-covered expenses. After an annual out-of-pocket maximum is met for medical and prescription drugs during a calendar year, the individual member or family will no longer be required to pay a copay or coinsurance for medical and prescription drug covered expenses for the remainder of that year. The member remains responsible for non-covered expenses.

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| **Lifetime Maximum** | Unlimited | |
| **Covered Services** | **PPO: Per Member Copay** | **Non-PPO: Per Member Copay** |
| **Hospital Medical Services** *(subject to utilization review for inpatient services; waived for emergency admissions)* | | |
| ➢ Semi-private room, meals & special diets, & ancillary services | 20% | 40%[2] *(benefit limited to $600/day)* |
| ➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)* | 20% | 40%[2] *(benefit limited to $350/day)* |
| **Ambulatory Surgical Centers** | | |
| ➢ Outpatient surgery, services & supplies | 20% | 40% *(benefit limited to $350/day)* |
| **Skilled Nursing Facility** *(subject to utilization review)* | | |
| ➢ Semi-private room, services & supplies *(limited to 100 days/calendar year; limit does not apply to mental health and substance abuse)* | 20% | 40% |
| **Hospice Care** | | |
| Inpatient or outpatient services for members with life expectancy of one year or less | 20%[1] | |

[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 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 | PPO: Per Member Copay | Non-PPO: Per Member Copay |
|---|---|---|
| **Home Health Care** *(subject to utilization review)* | | |
| ➢ Services & supplies from a home health agency *(limited to 100 visits/calendar year, one visit by a home health aide equals four hours or less; not covered while member receives hospice care)* | 20% | 40% |
| **Home Infusion Therapy** *(subject to utilization review)* | | |
| ➢ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services | 20% | 40% *(benefit limited to $600/day)* |
| **Physician Medical Services** | | |
| ➢ Office & home visits *(includes retail health clinic)* | $15/visit[1] *(deductible waived)* | 40% |
| ➢ Online visits | $15/visit *(deductible waived)* | 40% |
| ➢ Hospital & skilled nursing facility visits | 20% | 40% |
| ➢ Surgeon & surgical assistant; anesthesiologist or anesthetist | 20% | 40% |
| **Diagnostic X-ray & Lab** | | |
| ➢ MRI, CT scan, PET scan & nuclear cardiac scan | 20% | 40% *(benefit limited to $800/test)* |
| ➢ Other diagnostic x-ray & lab . | 20% | 40% *(benefit limited to $350/day at an Outpatient hospital)* |
| **Preventive Care Services** Preventive Care Services including*, physical exams, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunizations, health education, intervention services, HIV testing), and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration. *This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law. | No copay *(deductible waived)* | 40% |
| **Physical Therapy, Physical Medicine & Occupational Therapy, including Chiropractic Services** *(limited to 24 visits/calendar year; additional visits may be authorized)* | 20% | 40% *(benefit limited to $350/day at an Outpatient hospital)* |
| **Speech Therapy** | | |
| ➢ Outpatient speech therapy following injury or organic disease . | 20% | 40% *(benefit limited to $350/day at an Outpatient hospital)* |
| **Acupuncture** | | |
| ➢ Services for the treatment of disease, illness or injury *(limited to 12 visits/calendar year)* | 20%[2] | 40%[2] |
| **Temporomandibular Joint Disorders** | | |
| ➢ Splint therapy & surgical treatment | 20% | 40% |
| **Pregnancy & Maternity Care** | | |
| ➢ Physician office visits | $15/visit[1] *(deductible waived)* | 40% |
| ➢ Prescription drug for abortion *(mifepristone)* | 20% | 40% |
| Normal delivery, cesarean section, complications of pregnancy & abortion | | |
| ➢ Inpatient physician services | 20% | 40% |
| ➢ Hospital & ancillary services | 20% | 40%[3] |
| **Organ & Tissue Transplants** *(subject to utilization review; specified transplants covered only when performed at Centers of Medical Excellence [CME] and Blue Distinction Centers for Specialty Care [BDCSC] for California; Blue Distinction Centers for Specialty Care [BDCSC] for out of California)* | | |
| ➢ Inpatient services provided in connection with non-investigative organ or tissue transplants | 20% | |

[1] The dollar copay applies only to the visit itself. An additional 20% copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

[2] Acupuncture services can be performed by a certified acupuncturist (C.A.), a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a podiatrist (D.P.M.), or a dentist (D.D.S.).

[3] For California facilities, a discount applies if the facility has a contract with 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 | PPO: Per Member Copay | Non-PPO: Per Member Copay |
|---|---|---|
| **Organ & Tissue Transplants (continued)** | | |
| ➢ 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** *(subject to utilization review; medically necessary surgery for weight loss, only for morbid obesity, covered only when performed at a Blue Distinction Centers for Specialty Care [BDCSC]* | | |
| ➢ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity | 20% | |
| **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)* | 40% |
| **Prosthetic Devices** | | |
| ➢ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; & the first pair of contact lenses or eyeglasses when required as a result of eye surgery*)* | 20% | 40% |
| **Durable Medical Equipment** | | |
| ➢ Rental or purchase of DME including hearing aids, dialysis equipment & supplies, & therapeutic shoes & inserts for members with diabetes | 20% | 40% |
| **Related Outpatient Medical Services & Supplies** | | |
| ➢ Ground or air ambulance transportation, services & disposable supplies | 20%[1] | |
| ➢ Blood transfusions, blood processing & the cost of unreplaced blood & blood products | 20%[1] | |
| ➢ Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)* | 20%[1] | |
| **Emergency Care** | | |
| ➢ Emergency room services & supplies *($100 deductible waived if admitted)* | 20% | 20% |
| ➢ Inpatient hospital services & supplies | 20% | 20% first 48 hours; 40% after 48 hours[3] *(unless member can't be moved safely)* |
| ➢ Physician services | 20% | 20% |
| **Mental or Nervous Disorders and Substance Abuse** | | |
| ➢ Inpatient facility-based care *(subject to utilization review; waived for emergency admissions)* | 20% | 40%[3] |
| ➢ Inpatient physician visits | 20% | 40% |
| ➢ Outpatient facility-based care | 20% | 40%[3] *(benefit limited to $350/day)* |
| ➢ Physician office visits | $15/visit[2] *(deductible waived)* | 40% |

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

[2] The dollar copay applies only to the visit itself. An additional 20% copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

[3] For California facilities, a discount applies if the facility has a contract with 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 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.**

**For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to https://le.anthem.com/pdf?x=CA_LG_PPO**