

Your summary of benefits



Anthem Blue Cross

Your Plan: City of Merced Low Option EPO

Your Network: EPO

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Certificate of Insurance or Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible <i>See notes section to understand how your deductible works.</i>	\$100 single / \$300 family (aggregate)	\$0
Out-of-Pocket Limit <i>When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.</i> <i>Copays and deductibles are waived for members with Medicare as primary payor.</i>	\$1,600 single / \$3,300 family	\$0
Preventive care/screening/immunization <i>In-network preventive care is not subject to deductible, if your plan has a deductible.</i>	No charge	Not covered
Doctor Home and Office Services Primary care visit to treat an injury or illness <i>Deductible does not apply.</i>	\$20 copay per office visit / \$25 copay per home visit	Not covered
Specialist care visit <i>Deductible does not apply.</i>	\$20 copay per office visit / \$25 copay per home visit	Not covered
Prenatal and Post-natal Care <i>Deductible does not apply.</i>	\$0 copay per visit	Not covered

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<p>Other practitioner visits:</p> <ul style="list-style-type: none"> Retail health clinic Internet-based consultations <i>Deductible does not apply.</i> Chiropractor services <i>Coverage for In-Network Provider is limited to 30 visit limit per benefit period. Deductible applies.</i> Acupuncture 	<ul style="list-style-type: none"> Not covered \$20 copay per visit \$5 copay per visit Not covered 	<ul style="list-style-type: none"> Not covered Not covered Not covered Not covered
<p>Other services in an office:</p> <ul style="list-style-type: none"> Allergy testing Chemo/radiation therapy Hemodialysis Prescription drugs <i>For the drug itself dispensed in the office thru infusion/injection. Excludes contraceptive injections in a physician's office.</i> 	<ul style="list-style-type: none"> 0% coinsurance 0% coinsurance 0% coinsurance 0% coinsurance 	<ul style="list-style-type: none"> Not covered Not covered Not covered Not covered
<p>Diagnostic Services</p> <p>Lab:</p> <ul style="list-style-type: none"> Office Freestanding Lab Outpatient Hospital 	<ul style="list-style-type: none"> 0% coinsurance 0% coinsurance 0% coinsurance 	<ul style="list-style-type: none"> Not covered Not covered Not covered
<p>X-ray:</p> <ul style="list-style-type: none"> Office Freestanding Radiology Center Outpatient Hospital 	<ul style="list-style-type: none"> 0% coinsurance 0% coinsurance 0% coinsurance 	<ul style="list-style-type: none"> Not covered Not covered Not covered
<p>Advanced diagnostic imaging (for example, MRI/PET/CAT scans):</p> <ul style="list-style-type: none"> Office Freestanding Radiology Center Outpatient Hospital 	<ul style="list-style-type: none"> 0% coinsurance 0% coinsurance 0% coinsurance 	<ul style="list-style-type: none"> Not covered Not covered Not covered

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<p>Emergency and Urgent Care</p> <p>Emergency room facility services <i>This is for the hospital/facility charge only. The ER physician charge may be separate. Copay waived if admitted.</i></p> <p>Emergency room doctor and other services</p>	<p>\$200 copay per admission and then 0% coinsurance</p> <p>0% coinsurance</p>	<p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p>Ambulance (air and ground)</p>	<p>\$50 copay per trip</p>	<p>Covered as In-Network</p>
<p>Urgent Care (office setting) <i>Deductible does not apply.</i></p>	<p>\$20 copay per visit</p>	<p>Not covered</p>
<p>Outpatient Mental/Behavioral Health and Substance Abuse</p> <p>Doctor office visit</p> <p>Facility visit: Facility fees</p>	<p>\$20 copay per visit; deductible does not apply</p> <p>0% coinsurance after deductible is met.</p>	<p>Not covered</p> <p>Not covered</p>
<p>Outpatient Surgery</p> <p>Facility fees: Hospital <i>Deductible applies.</i> Freestanding Surgical Center <i>Deductible applies.</i></p> <p>Doctor and other services</p>	<p>\$100 copay per occurrence</p> <p>\$100 copay per occurrence</p> <p>0% coinsurance</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>

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<p>Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)</p> <p>Facility fees (for example, room & board) <i>Deductible applies.</i></p> <p>Doctor and other services <i>Deductible applies.</i></p>	<p>\$100 copay per day for the first 3 days per admission</p> <p>0% coinsurance</p>	<p>Not covered</p> <p>Not covered</p>
<p>Recovery & Rehabilitation</p> <p>Home health care <i>Coverage for In-Network Provider is limited to 100 visit limit per benefit period. Not covered while member receives hospice care. Deductible applies.</i></p>	<p>\$20 copay per visit</p>	<p>Not covered</p>
<p>Rehabilitation services (for example, physical/speech/occupational therapy):</p> <p>Office <i>Benefits provided, with submission of a treatment plan, as long as treatment is deemed medically necessary. Deductible applies.</i></p> <p>Outpatient hospital <i>Deductible applies.</i></p> <p>Habilitation services <i>Deductible applies.</i></p>	<p>\$20 copay per visit</p> <p>\$20 copay per visit</p> <p>\$20 copay per visit</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p>Cardiac rehabilitation</p> <p>Office <i>Deductible applies.</i></p> <p>Outpatient hospital <i>Deductible applies.</i></p>	<p>\$20 copay per visit</p> <p>\$20 copay per visit</p>	<p>Not covered</p> <p>Not covered</p>
<p>Skilled nursing care (in a facility) <i>Coverage for In-Network Provider is limited to 100 day limit per benefit period.</i></p>	<p>0% coinsurance</p>	<p>Not covered</p>
<p>Hospice</p>	<p>0% coinsurance</p>	<p>Not covered</p>
<p>Durable Medical Equipment</p>	<p>20% coinsurance</p>	<p>Not covered</p>

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Prosthetic Devices <i>Surgically implanted devices are no charge.</i>	20% coinsurance	Not covered
Temporomandibular Joint Disorders <i>Deductible applies.</i>	\$20 copay per visit	Not covered
Family Planning and Infertility Services		
Contraceptive Injections <i>Deductible applies.</i>	\$25/injection plus \$20 office visit copay	Not covered
Diagnosis and Treatment of cause of Infertility	50% of allowed charges	Not covered
Home Infusion Therapy	0% coinsurance	Not covered

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Notes:

- This Summary of Benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this Summary of Benefits. This Summary of Benefits, as updated, is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care (as applicable).
- In addition to the benefits described in this summary, coverage may include additional benefits, depending upon the member's home state. The benefits provided in this summary are subject to federal and California laws. There are some states that require more generous benefits be provided to their residents, even if the master policy was not issued in their state. If the member's state has such requirements, we will adjust the benefits to meet the requirements.
- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.
- All medical services subject to a coinsurance are also subject to the annual medical deductible.
- Annual Out-of-Pocket Maximums includes deductible, copays, coinsurance and prescription drug.
- Preventive Care Services includes physical exam, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunization, health education, intervention services, HIV testing) and additional preventive care for women provided for in the guidance supported by Health Resources and Service Administration.
- For plans with an office visit copay, the copay applies to the actual office visit and additional cost shares may apply for any other service performed in the office (i.e., X-ray, lab, surgery), after any applicable deductible.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- 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.
- Additional visits maybe authorized if medically necessary. Pre-service review must be obtained prior to receiving the additional services.
- Transplants covered only when performed at Centers of Medical Excellence or Blue Distinction Centers.
- Transplant travel expense for an authorized, specified transplant at a CME or Blue Distinction Center: 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.
- Bariatric Surgery covered only when performed at Blue Distinction Center for Specialty Care for Bariatric Surgery.
- Skilled Nursing Facility day limit does not apply to mental health and substance abuse.
- Respite Care limited to 5 consecutive days per admission.
- Freestanding Lab and Radiology Center is defined as services received in a non-hospital based facility.

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Questions:(855) 333-5730 or visit us at www.anthem.com/ca

CA/L/F/EPO/GE2008 (E8 100/10/100)/01-19 Low Option EPO

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- 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 coverage do not exceed 100% of the covered expense
- 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_EPO
- This plan includes custom benefits that may supersede some of the information included in the Limitations and Exclusions link provided here. Please see your EOC for full details on your covered benefits.
- For additional information on this plan, please visit sbc.anthem.com to obtain a Summary of Benefit Coverage.