City of Chico PPO 80

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. Certain Covered Services have maximum visit and/or day limits per year. The number of visits and/or days allowed for these services will begin accumulating on the first visit and/or day, regardless of whether your Deductible has been met. 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 and Other Health Care Providers *(includes those not represented in the PPO provider network)*—The customary & reasonable charge for professional services or the reasonable charge for institutional services.

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 for all providers	$250/member; $500/family aggregate
Deductible for Anthem Blue Cross PPO hospital or residential treatment center	$100/admission

Annual Out-of-Pocket Maximums	
PPO Providers & Other Health Care Providers	$3,250/member/year; $6,500/family/year
Non-PPO Providers	$10,000/member/year; $20,000/family/year

The following do not apply to out-of-pocket maximums: non-covered expenses. After a member reaches the out-of-pocket maximum, the member remains responsible for costs in excess of the covered expense; amounts related to a transplant unrelated donor search.

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%[1]
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	20% + $50	40%[1]
Ambulatory Surgical Centers		
➢ Outpatient surgery, services & supplies	20%	40% *(benefit limited to $350/day)*
Hemodialysis		
➢ Outpatient hemodialysis 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)*	20%	20%
Hospice Care		
➢ Inpatient or outpatient services; family bereavement services	20%[2]	
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%	20%

[1] For California facilities, a discount will be applied if the facility has a contract with Anthem Blue Cross for fee-for-service business. For California facilities without a contract, covered expense for hospital services and supplies is reduced by 25%, resulting in higher costs for members.

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

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay
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%	20% *(benefit limited to $600/day)*
Physician Medical Services		
➢ Office & home visits	$25/visit[1] *(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 *(subject to utilization review)*	20%	40%
➢ Other diagnostic x-ray & lab	$25/visit	40%
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)*	Not covered
➢ Immunizations *(birth through age six)*	No copay *(deductible waived)*	Not covered
➢ Routine physical exams, immunizations, diagnostic X-ray & lab, for routine physical exam *(members 7 years old and older)*	No copay/exam *(deductible waived)*	Not covered
➢ Adult preventive services *(including mammograms, Pap smears, prostate cancer screenings & colorectal cancer screenings)*	No copay/exam *(deductible waived)*	Not covered
Physical Therapy, Physical Medicine & Occupational Therapy	$25/visit	40%
Chiropractic Services *(limited to 12 visits/calendar year)*	$25/visit	40%
Speech Therapy		
➢ Outpatient speech therapy following injury or organic disease	$25/visit	40%
Acupuncture		
➢ Services for the treatment of disease, illness or injury *(limited to 20 visits/calendar year)*	$25/visit[2]	$25/visit[2]
Temporomandibular Joint Disorders		
➢ Splint therapy & surgical treatment	20%	40%
Pregnancy & Maternity Care		
➢ Physician office visits	No copay *(deductible waived)*	40%
➢ Prescription drug for elective abortion *(mifepristone)*	20%	40%
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	20%	40%
➢ Hospital & ancillary services	20%	40%[3]
Organ & Tissue Transplants *(subject to utilization review; specified organ transplants covered only when performed at Centers of Medical Excellence [CME])*		
➢ Inpatient services provided in connection with non-investigative organ or tissue transplants	20%	
➢ Transplant travel expense for an authorized, specified transplant at *CME* *(recipient & companion transportation limited to $10,000 per transplant)*	No copay *(deductible waived)*	
➢ Unrelated donor search, limited to $30,000 per transplant		

[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 will be applied if the facility has a contract with Anthem Blue Cross for fee-for-service business. For California facilities without a contract, covered expense for hospital services and supplies is reduced by 25%, resulting in higher costs for members.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay
Bariatric Surgery *(subject to utilization review; medically necessary surgery for weight loss, only for morbid obesity, covered only when performed at Centers of Medical Excellence [CME])*		
➢ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity	20%	
➢ Bariatric travel expense when member's home is 50 miles or more from the nearest bariatric *CME (member's transportation to & from CME limited to $130/person/trip for 3 trips [pre-surgical visit, initial surgery & one follow-up visit]; one companion's transportation to & from CME limited to $130/person/trip for 2 trips [initial surgery & one follow-up visit]; hotel for member & one companion limited to one room double occupancy & $100/day for 2 days/trip, or as medically necessary, for pre-surgical & follow-up visit; hotel for one companion limited to one room double occupancy & $100/day for duration of member's initial surgery stay for 4 days; other reasonable expenses limited to $25/day/person for 4 days/trip)*	No copay *(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	$25/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; & therapeutic shoes & inserts for members with diabetes	20%	40%
Durable Medical Equipment		
➢ Rental or purchase of DME including hearing aids, dialysis equipment & supplies *(hearing aids benefit is available for one hearing aid per ear every three years)*	20%	40%
Related Outpatient Medical Services & Supplies		
➢ Ground or air ambulance transportation, services & disposable supplies	20%[3]	
➢ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	20%[3]	
➢ Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)*	20%[3]	
Emergency Care		
➢ Emergency room services & supplies	20%	20%
➢ Inpatient hospital services & supplies	20%	20%
➢ Physician services	20%	20%
Mental or Nervous Disorders and Substance Abuse		
Inpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	20%	40%[1]
➢ Inpatient physician visits	20%	40%
Outpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	20%	40%[1]
➢ Outpatient physician visits *(pre-service review required after the 12th visit)*	$25/visit[2] *(deductible waived)*	40%

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

[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] 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.

Premier Plan 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 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.

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 and alcohol or drug dependence, 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, 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, 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 infusion therapy provider, except 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.

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 Evidence of Coverage (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.

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 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 , except 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.

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.

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. 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 requirement 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 EOC.

Acupuncture. Acupuncture treatment, 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 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.

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City of Chico PPO 80 Plan

EXPRESS SCRIPTS®

	Home Delivery	Retail (in network)
Generics	$10.00	$5.00
Preferred brands	$20.00	$10.00
Non preferred brands (no generic)	$50.00	$25.00
Non preferred brands (generics available)	$50.00	$25.00
Deductible (Individual / Family)	None	
Out of Pocket Maximum (Individual / Family)	$3,350 / $6,700	

SAVING WITH HOME DELIVERY

When you get maintenance medications (those prescription drugs you take regularly) at a retail pharmacy, you could be paying more than you need to. Use Express Scripts home delivery pharmacy services* for drugs to treat an ongoing condition (3 months or longer). We will deliver up to a 90-day supply right to you with free standard shipping.

SAVING WITH GENERICS

FDA-approved generics are as safe and effective as their brand-name counterparts. If you're taking a brand-name drug, talk to your doctor and ask whether a less expensive generic drug could treat your condition. If your doctor agrees, ask your doctor to write a new prescription for the generic that you can fill through your prescription benefit.

*If you purchase a brand-name medication when a generic medication is available, you will pay the generic copayment, plus the difference in cost between the brand and the generic.

Home delivery... it's quick and easy

» Call us

We'll contact your doctor to get a new 90-day prescription for home delivery.

or

» Talk to your doctor

Ask your doctor for a new prescription for up to a 90-day supply. Have your doctor call us at 1.888.327.9791 for instructions on how to fax your prescription.

Manage your prescriptions online and on the go	Register on Express-Scripts.com	Download the Express Scripts mobile app
Receive prescription reminders	√	√
Search for potential lower-cost options using **My Rx Choices**®	√	√
Receive prescription and drug interaction alerts	√	√
Show your virtual ID card at the retail pharmacy		√
Contact a pharmacist	√	
Check your coverage, claims and balances	√	
Print claim forms, order forms and fax forms	√	

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