



# RETA TRUST EPO PLAN (500/25)

Anthem Blue Cross EPO members must receive health care services from Anthem PPO (Prudent Buyer) network providers exclusively, unless they receive authorized referrals or need emergency and/or out-of-area urgent care. Emergency services received from a Non-PPO hospital without an authorized referral are covered only for the first 48 hours. Coverage will continue beyond 48 hours if the member cannot be moved safely.

In addition to dollar and percentage copays, members are responsible for deductibles, as described below.

Members are also responsible for all costs over the plan maximums. Plan maximums and other important information appear in *italics*.

## Explanation of Covered Expense

Plan payments apply to 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 & Other Health Care Providers** (*includes those not represented in the PPO provider network*)— All eligible health care expenses charged by a Non-PPO provider (including services in connection with emergency care) are limited to the customary and reasonable amount that has been established for that service.

**When using Non-PPO and Other Health Care Providers, members are responsible for any difference between the allowed amount & actual charges, as well as any percentage or dollar copay.**

<b>Calendar year deductible</b>	\$500/Individual \$1,000/Family	
<b>Annual Out of Pocket Maximum</b>	Individual	Family
	\$2,500	\$5,000
<b>Lifetime Maximum</b>	\$5,000,000/member	
Covered Services	PPO: Per Member Copay <sup>1</sup>	
<b>Hospital Medical Services</b> ( <i>preauthorization required; waived for emergency admissions</i> )		
➤ Semi-private room, meals & special diets, & ancillary services	10% copay	
➤ Outpatient medical care, surgical services & supplies ( <i>hospital care other than emergency room care</i> )	10% copay	
<b>Ambulatory Surgical Centers</b>		
➤ Outpatient surgery, services & supplies	10% copay	
<b>Skilled Nursing Facility</b> ( <i>preauthorization required</i> )		
➤ Semi-private room, services & supplies ( <i>limited to 120 days/calendar year</i> )	10% copay	
<b>Hospice Care</b>		
➤ Inpatient or outpatient services for members with up to one year life expectancy.	10% copay <sup>2</sup>	
<b>Home Health Care</b> ( <i>preauthorization required</i> )		
➤ Services & supplies from a home health agency ( <i>limited to 120 visits/calendar year, one visit by home health aide equals four hours or less; not covered while member receives hospice care</i> )	10% copay	
<b>Home Infusion Therapy</b> ( <i>preauthorization required</i> )	10% copay	
➤ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services		
<b>Physician Medical Services</b>		
➤ Office & home visits	\$25/visit ( <i>deductible waived</i> )	
➤ Allergy treatment & serum	\$25/visit ( <i>deductible waived</i> )	
➤ Hospital & skilled nursing facility visits	10% copay	
➤ Surgeon & surgical assistant; anesthesiologist or anesthetist	10% copay	
<b>Diagnostic X-ray &amp; Lab</b>	10% copay	

<sup>1</sup>Non-emergency services from Non-PPO providers are covered only with an authorized referral.

<sup>2</sup>These providers are not represented in the Anthem Blue Cross PPO network, therefore the member pays no copay. These charges are subject to the customary and reasonable limitation.

Covered Services	PPO: Per Member Copay <sup>1</sup>
<b>Well Baby &amp; Well-Child Care</b>	
➤ Routine physical examinations ( <i>birth through age two</i> )	\$25/visit (deductible waived)
➤ Immunizations ( <i>birth through age six</i> )	\$25/visit (deductible waived)
<b>Preventive Care</b>	
➤ Routine physical exams, diagnostic X-ray & lab for routine physical exams ( <i>age 3 &amp; older</i> ) and immunizations ( <i>ages 7 &amp; older</i> ) ( <i>limited to \$500/calendar year; routine vision exams not covered</i> )	\$25/visit (deductible waived)
<b>Physical Therapy, Physical Medicine &amp; Occupational Therapy</b> ( <i>limited to 24 visits/calendar year; additional visits may be authorized</i> )	\$25/visit (deductible waived)
<b>Speech Therapy</b>	
➤ Outpatient speech therapy following injury or organic disease	\$25/visit (deductible waived)
<b>Chiropractic Care</b> ( <i>limited to 24 visits/calendar year</i> )	\$25/visit (deductible waived)
<b>Acupuncture</b>	
➤ Services for pain management only ( <i>limited to \$25/visit &amp; 12 visits/calendar year</i> )	\$25/visit <sup>2</sup> (deductible waived)
<b>Temporomandibular Joint Disorders</b>	
➤ Splint therapy & surgical treatment ( <i>lifetime maximum of \$1,250</i> )	10% copay
<b>Pregnancy &amp; Maternity Care</b>	
➤ Physician office visits Normal delivery, cesarean section, complications of pregnancy ( <i>newborn routine nursery care covered when newborn is enrolled in plan within 31 days of birth</i> )	\$25/visit (deductible waived)
➤ Inpatient physician services	10% copay
➤ Hospital & ancillary services	10% copay
<b>Organ &amp; Tissue Transplants</b> ( <i>preauthorization required; specified organ transplants covered only when performed at a Center of Expertise [COE]</i> )	
➤ Inpatient services provided in connection with non-investigative organ or tissue transplants	10% copay <sup>3</sup>
➤ Physician office visits ( <i>including specialists and consultants</i> )	\$25/visit (deductible waived)
➤ Transplant travel expense for an authorized, specified transplant at a COE ( <i>recipient &amp; companion transportation limited to 6 trips/episode &amp; \$250/person/trip for round-trip coach airfare, hotel limited to 1 room double occupancy &amp; \$100/day for 21 days/trip, other expenses limited to \$25/day/person for 21 days/trip; donor transportation limited to 1 trip/episode &amp; \$250 for round-trip coach airfare, hotel limited to \$100/day for 7 days, other expenses limited to \$25/day for 7 days</i> )	10% copay <sup>3</sup>
<b>Diabetes Education Programs</b> ( <i>requires physician supervision</i> )	
➤ Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	\$25/visit (deductible waived)

<sup>1</sup>Non-emergency services from Non-PPO providers are covered only with an authorized referral. These charges are subject to the customary and reasonable limitation.

<sup>2</sup>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.).<sup>3</sup> Not covered unless transplant takes place at a Center of Expertise.

Covered Services	PPO: Per Member Copay <sup>1</sup>
<b>Prosthetic Devices</b>	
➤ 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% copay
<b>Durable Medical Equipment</b>	
➤ Rental or purchase of DME, dialysis equipment & supplies, & therapeutic shoes & inserts for members with diabetes	10% copay
<b>Related Outpatient Medical Services &amp; Supplies</b>	
➤ Ground or air ambulance transportation, services & disposable supplies	10% copay <sup>2</sup>
➤ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	10% copay <sup>2</sup>
➤ Autologous blood ( <i>self-donated blood collection, testing, processing &amp; storage for planned surgery</i> )	10% copay <sup>2</sup>
<b>Emergency Care</b>	
➤ Emergency room services & supplies	10% copay
➤ Inpatient hospital services & supplies	10% copay
➤ Physician services	10% copay
<b>Mental or Nervous Disorders and Substance Abuse</b>	
➤ Facility-based care ( <i>preauthorization required</i> )	10% copay
➤ Outpatient physician visits for psychotherapy & psychological testing	\$25/visit ( <i>deductible waived</i> )

<sup>1</sup>Services from Non-PPO providers are covered only with an authorized referral. These charges are subject to the customary and reasonable limitation.

<sup>2</sup>These providers are not represented in the Anthem Blue Cross PPO network, therefore member pays no copay. These charges are subject to the customary and reasonable limitation.

**This Summary of Benefits is a brief review of benefits. Once enrolled, members will receive a Summary Plan Description, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.**

# Anthem Blue Cross 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 from BC Life & Health, 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.

**Crime or Nuclear Energy.** Conditions that result from (1) war; (2) the member's commission of or attempt to commit a felony; or (3) 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.

**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.

**Government Treatment.** Any services provided by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law.

**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.

**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.

**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 services, extraction of teeth, treatment to the teeth or gums. Cosmetic dental surgery or other dental services for beautification.

**Hearing Aids.**

**Optometric Services or Supplies.** Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions. Eyeglasses or contact lenses.

**Outpatient Occupational Therapy.** Outpatient occupational therapy, except as specified in the SPD.

**Outpatient Speech Therapy.** Outpatient speech therapy, except as specified in the SPD.

**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.

**Elective Abortion.**

**Obesity.** Services primarily for weight reduction or the treatment of obesity. This exclusion does not apply to surgical treatment of morbid obesity, as determined, and if the treatment is authorized in advance as medically necessary and appropriate.

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

**Sterilization or Reversal of Sterilization**

**Infertility Treatment.** Any services or supplies furnished in connection with the treatment of infertility, including, but not limited to, 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 foot complications.

**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.

**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.

**Food Supplements.** Food or dietary supplements.

**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 in the SPD.

**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 as specified under the SPD.

**Outpatient Prescription Drugs and Medications.** Outpatient prescription drugs or medications and insulin. Any non-prescription, over-the-counter patent or proprietary drug or medicine. Cosmetics, health or beauty aids. These services may be covered under your Prescription Drug Program.

**Contraceptive Devices.** Contraceptive devices prescribed for birth control.

**Diabetic Supplies.** Prescription and non-prescription diabetic supplies.

**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.

**Pre-existing Conditions Exclusions.** No payment will be made for Services or supplies for the treatment of a pre-existing condition during a period of twelve months following (a) the member's effective date or (b) the first day of any waiting period required by the group, whichever is earlier. However, this limitation does not apply to a child born to or newly adopted by an enrolled subscriber or spouse, or to conditions of pregnancy. Also, if a member was covered under creditable coverage the time spent under the creditable coverage will be used to satisfy or partially satisfy the twelve-month period.

**Third Party Liability** – The plan 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, dental, prescription drug or vision coverage so that the services received from all group coverages do not exceed 100% of the covered expense.

Services provided by Blue Cross of California using the trade name Anthem Blue Cross. Independent licensee of the Blue Cross Association.

[anthem.com/ca](http://anthem.com/ca)