

Your summary of benefits



Anthem Blue Cross Life and Health Insurance

County of San Benito

Your Plan: Anthem HDHP PPO (LHSA500)

Your Network: Prudent Buyer PPO

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. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.</i> | \$1,350 single / \$2,700 family | \$2,700 single / \$8,100 family |
| 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> | \$4,000 single / \$8,000 family | \$8,000 single / \$16,000 family |
| Preventive care/screening/immunization <i>In-network preventive care is not subject to deductible, if your plan has a deductible.</i> | No charge | 30% coinsurance |
| Doctor Home and Office Services | | |
| Primary care visit to treat an injury or illness | \$25 copay per visit | 30% coinsurance |
| Specialist care visit | \$25 copay per visit | 30% coinsurance |
| Prenatal and Post-natal Care | \$25 copay per visit | 30% coinsurance |
| Other practitioner visits: | | |
| Retail health clinic | \$25 copay per visit | 30% coinsurance |
| On-line Visit | \$25 copay per visit | 30% coinsurance |
| Chiropractor services <i>Coverage for In-Network Provider for Chiropractor services and Acupuncture combined is limited to 26 visit limit per calendar year.</i> | 10% coinsurance | 30% coinsurance |
| Acupuncture <i>Coverage for In-Network Provider for Chiropractor services and Acupuncture combined is limited to 26 visit limit per calendar year.</i> | 10% coinsurance | 30% coinsurance |

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|--|--|--|
| Other services in an office: Allergy testing Chemo/radiation therapy Hemodialysis Prescription drugs <i>For the drugs itself dispensed in the office thru infusion/injection</i> | 10% coinsurance 10% coinsurance 10% coinsurance 10% coinsurance | 30% coinsurance 30% coinsurance 30% coinsurance 30% coinsurance |
| Diagnostic Services Lab: Office Freestanding Lab Outpatient Hospital | \$25 copay per visit \$25 copay per visit \$25 copay per visit | 30% coinsurance 30% coinsurance 30% coinsurance |
| X-ray: Office Freestanding Radiology Center Outpatient Hospital | \$25 copay per visit \$25 copay per visit \$25 copay per visit | 30% coinsurance 30% coinsurance 30% coinsurance |
| Advanced diagnostic imaging (for example, MRI/PET/CAT scans): Office Freestanding Radiology Center Outpatient Hospital | \$25 copay per visit \$25 copay per visit \$25 copay per visit | 30% coinsurance 30% coinsurance 30% coinsurance |
| Emergency and Urgent Care Emergency room facility services Emergency room doctor and other services | 10% coinsurance 10% coinsurance | Covered as In-Network Covered as In-Network |
| Ambulance (air and ground) | 10% coinsurance | Covered as In-Network |

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|---|---|--|
| Urgent Care (office setting) | 10% coinsurance | 30% coinsurance |
| Outpatient Mental/Behavioral Health and Substance Abuse | | |
| Doctor office visit | \$25 copay per visit for non-preventive visit; after deductible is met. | 30% coinsurance |
| Facility visit: | | |
| Facility fees | 10% for non-preventive visit; after deductible is met. | 30% coinsurance |
| Outpatient Surgery | | |
| Facility fees: | | |
| Hospital | \$250/admission | 30% coinsurance |
| Freestanding Surgical Center | \$250/admission | 30% coinsurance |
| Doctor and other services | 10% coinsurance | 30% coinsurance |
| Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse) | | |
| Facility fees (for example, room & board) | \$250/day up to 3 days | 30% coinsurance |
| Doctor and other services | 10% coinsurance | 30% coinsurance |
| Recovery & Rehabilitation | | |
| Home health care | 10% coinsurance | 30% coinsurance |
| <i>Coverage for In-Network Provider and Non-Network Provider combined is limited to 100 visit limit per benefit period.</i> | | |

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|--|---|---|
| Rehabilitation services (for example, physical/speech/occupational therapy): Office Outpatient hospital Habilitation services Office and Outpatient hospital | 10% coinsurance 10% coinsurance 10% coinsurance | 30% coinsurance 30% coinsurance 30% coinsurance |
| Cardiac rehabilitation Office Outpatient hospital | 10% coinsurance 10% coinsurance | 30% coinsurance 30% coinsurance |
| Skilled nursing care (in a facility) <i>Coverage for In-Network Provider and Non-Network Provider combined is limited to 100 day limit per benefit period.</i> | 10% coinsurance | 30% coinsurance |
| Hospice | 10% coinsurance | 30% coinsurance |
| Durable Medical Equipment | 10% coinsurance | 30% coinsurance |
| Prosthetic Devices | 10% coinsurance | 30% coinsurance |

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| Covered Prescription Drug Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|--|
| Pharmacy Deductible | Combined with medical deductible | Combined with medical deductible |
| Pharmacy Out of Pocket | Combined with medical OOP | Combined with medical OOP |
| Preventive Pharmacy <i>Preventive Rx Plus</i> | No charge (retail only) | Not covered |
| Prescription Drug Coverage <i>This plan uses an Essential formulary List. Drugs not on the list are not covered. You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days.</i> | | |
| Tier1 - Typically Generic <i>Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program) You pay additional copays or coinsurance for retail fills that exceed 30 days.</i> | Tier1 - \$15 copay per prescription (retail only) and \$30 copay per prescription (home delivery only) | Not covered |
| Tier2 - Typically Preferred / Brand <i>Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program)</i> | Tier 2- Typically Preferred Brand & non-preferred generic drugs \$25 copay per prescription (retail only) and \$50 copay per prescription (home delivery only). | Not covered |
| Tier3 - Typically Non-Preferred / Specialty Drugs <i>Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program)</i> | Tier 3 - Typically Non-Preferred Brand and generic drugs \$35 copay per prescription (retail only) and \$70 copay per prescription (home delivery only). | Not covered |

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|--|--|--|
| <p>Tier4 - Typically Specialty Drugs <i>Classified specialty drugs must be obtained through our Specialty Pharmacy Program and are subject to the terms of the program. Covers up to a 30 day supply (retail pharmacy and home delivery program)</i></p> | <p>Tier 4 - Typically Specialty (brand and generic) 30% coinsurance up to \$150 per prescription (retail and home delivery).</p> | <p>Not covered</p> |

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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 out-of-pocket maximum is embedded meaning the cost shares of one family member will be applied to the individual out-of-pocket maximum; in addition, amounts for all family members apply to the family out-of-pocket maximum. No one member will pay more than the individual out-of-pocket maximum.
- The family deductible is non-embedded meaning the cost shares of all family members apply to one shared family deductible. The individual deductible only applies to individuals enrolled under single coverage.
- Pharmacy deductible and pharmacy out of pocket is combined with medical deductible and out-of-pocket.
- This Lumenos plan is an innovative type of coverage that allows a member to use a Health Savings Account to pay for medical care. The member can spend the money in the HSA account the way the member wants on medical care, prescription drugs and other qualified medical expenses. There are no copays or deductibles to satisfy first. Unused dollars can be saved from year to year to reduce the amount the member may have to pay in the future. If covered expenses exceed the member's available HSA dollars, the traditional health coverage is available after a limited out-of-pocket amount is paid by the member.
- All medical services subject to a copay or a coinsurance are also subject to the annual medical deductible.
- Annual Out-of-Pocket Maximums includes deductible, copays, coinsurance and prescription drug.
- In network and out of network deductible and out of pocket maximum are exclusive of each other.
- 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 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.
- If your plan includes out of network benefit and you use a non-network provider, you are responsible for any difference between the covered expense and the actual non-participating providers charge.
- Non-emergency, out-of-network air ambulance services are limited to Anthem maximum payment of \$50,000 per trip.
- 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.

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Questions: or visit us at

CA/L/F/CDHP/C-LL2047/NA/01-18

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- Certain types of physicians may not be represented in the PPO network in the state where the member receives services. If such physician is not available in the service area, the member's copay is the same as for PPO (with and without pre-notification, if applicable). Member is responsible for applicable copays, deductibles and charges which exceed covered expense.
- Additional visits maybe authorized if medically necessary. Pre-service review must be obtained prior to receiving the additional services.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- Transplants covered only when performed at Centers of Medical Excellence or Blue Distinction Centers.
- 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 five consecutive days per admission.
- Freestanding Lab and Radiology Center is defined as services received in a non-hospital based facility.
- 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
- Supply limits for certain drugs may be different, go to Anthem website or call customer service.
- Certain drugs require pre-authorization approval to obtain coverage.
- 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_CDHP
- For additional information on this plan, please visit sbc.anthem.com to obtain a Summary of Benefit Coverage.