Your summary of benefits

Anthem BlueCross

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City of Santa Rosa

Your Plan: Custom EPO 5 (0/25/0)

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 *See notes section to understand how your deductible works.*	$0 single / $0 family (No deductible)	$0 single / $0 family (No deductible)
Out-of-Pocket Limit *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.*	$1,500 single / $4,500 family	No limit
Doctor Home and Office Services **Preventive care/screening/immunization** *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	Not covered
Doctor Home and Office Services **Primary care visit to treat an injury or illness**	$25 copay per visit	Not covered
Specialist care visit	$25 copay per visit	Not covered
Prenatal and Post-natal Care	$25 copay per visit	Not covered
Other practitioner visits: Retail health clinic On-line Visit Chiropractor services Acupuncture	 $25 copay per visit $25 copay per visit Not covered Not covered	 Not covered Not covered Not covered Not covered

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Other services in an office:		
Allergy testing	0% coinsurance	Not covered
Chemo/radiation therapy	0% coinsurance	Not covered
Hemodialysis	0% coinsurance	Not covered
Prescription drugs *For the drugs itself dispensed in the office thru infusion/injection*	$25 copay per visit	Not covered
Diagnostic Services		
Lab:		
Office	$25 copay per visit	Not covered
Freestanding Lab	$25 copay per visit	Not covered
Outpatient Hospital	$25 copay per visit	Not covered
X-ray:		
Office	$25 copay per visit	Not covered
Freestanding Radiology Center	$25 copay per visit	Not covered
Outpatient Hospital	$25 copay per visit	Not covered
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office	$25 copay per visit	Not covered
Freestanding Radiology Center	$25 copay per visit	Not covered
Outpatient Hospital	$25 copay per visit	Not covered
Emergency and Urgent Care		
Emergency room facility services *This is for the hospital/facility charge only. The ER physician charge may be separate. Copay waived if admitted.*	$75 copay per admission	Covered as In-Network
Emergency room doctor and other services	0% coinsurance	Covered as In-Network
Ambulance (air and ground)	$50 copay per trip	Covered as In-Network

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Urgent Care (physician services)	0% coinsurance	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit	$25 copay per visit	Not covered
Facility visit:		
Facility fees	$250 copay per visit	Not covered
Outpatient Surgery		
Facility fees:		
Hospital *Subject to utilization review.*	$250 copay per visit	Not covered
Freestanding Surgical Center *Certain surgeries are subject to utilization review.*	$250 copay per visit	Not covered
Doctor and other services	0% coinsurance	Not covered
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)		
Facility fees (for example, room & board) *Subject to utilization review (waived for emergency admission).*	$250 copay per admission	Not covered
Doctor and other services	0% coinsurance	Not covered
Recovery & Rehabilitation		
Home health care *Subject to utilization review.*	0% coinsurance for visits 1 – 30, then $25 copay per visit thereafter	Not covered
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office	$25 copay per visit	Not covered
Outpatient hospital	$25 copay per visit	Not covered
Habilitation services	$25 copay per visit	Not covered

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Cardiac rehabilitation		
Office	0% coinsurance	Not covered
Outpatient hospital	0% coinsurance	Not covered
Skilled nursing care (in a facility) *Coverage for In-Network Provider is limited to 100 days per calendar year. If pre-authorization is not obtained, a 50% coinsurance penalty will apply.*	$250 copay per visit	Not covered
Hospice *Lifetime maximum of $5,000.*	$250 copay per admission	Not covered
Durable Medical Equipment *Subject to utilization review.*	0% coinsurance	Not covered
Prosthetic Devices	0% coinsurance	Not covered
Home Infusion Therapy *Subject to utilization review.*	0% coinsurance	Not covered
Bariatric Surgery *Subject to utilization review.*	0% coinsurance	Not covered
Organ & Tissue Transplants *Subject to utilization review.*	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.
- 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
- 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.