

Your summary of benefits



Anthem Blue Cross

City of Santa Rosa

Your Plan: Custom Anthem PPO HSA 2000/6000 20/40 – Hybrid Accumulation

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.</i>	\$2,000 single / \$6,000 family	\$2,000 single / \$6,000 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>	\$6,350 single / \$12,700 family	\$6,600 single / \$15,000 family
Doctor Home and Office Services		
Preventive care/screening/immunization <i>In-network preventive care is not subject to deductible, if your plan has a deductible.</i>	No charge	40% coinsurance
Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance
Specialist care visit	20% coinsurance	40% coinsurance
Prenatal and Post-natal Care	20% coinsurance	40% coinsurance
Other practitioner visits:		
Retail health clinic	20% coinsurance	40% coinsurance
On-line Visit	20% coinsurance	40% coinsurance
Chiropractor services <i>Coverage for In-Network Provider and Non-Network Provider combined is limited to 30 visits per calendar year.</i>	20% coinsurance	40% coinsurance
Acupuncture <i>Coverage for In-Network Provider and Non-Network Provider combined is limited to 20 visits per calendar year.</i>	20% coinsurance	40% coinsurance

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Other services in an office:</p> <ul style="list-style-type: none"> Allergy testing Chemo/radiation therapy Hemodialysis <i>Coverage for Out-of-Network Provider is limited to \$350 maximum per visit for free standing hemodialysis center.</i> Prescription drugs <i>For the drugs itself dispensed in the office thru infusion/injection</i> 	<p>20% coinsurance</p> <p>20% coinsurance</p> <p>20% coinsurance</p> <p>20% coinsurance</p>	<p>40% coinsurance</p> <p>40% coinsurance</p> <p>40% coinsurance</p> <p>40% coinsurance</p>
<p>Diagnostic Services</p> <p>Lab:</p> <ul style="list-style-type: none"> Office Freestanding Lab Outpatient Hospital 	<p>20% coinsurance</p> <p>20% coinsurance</p> <p>20% coinsurance</p>	<p>40% coinsurance</p> <p>40% coinsurance</p> <p>40% coinsurance</p>
<p>X-ray:</p> <ul style="list-style-type: none"> Office Freestanding Radiology Center Outpatient Hospital 	<p>20% coinsurance</p> <p>20% coinsurance</p> <p>20% coinsurance</p>	<p>40% coinsurance</p> <p>40% coinsurance</p> <p>40% coinsurance</p>
<p>Advanced diagnostic imaging (for example, MRI/PET/CAT scans):</p> <ul style="list-style-type: none"> Office <i>Coverage for Out-of-Network Provider is limited to \$800 maximum per test.</i> Freestanding Radiology Center <i>Coverage for Out-of-Network Provider is limited to \$800 maximum per test.</i> Outpatient Hospital <i>Coverage for Out-of-Network Provider is limited to \$800 maximum per test.</i> 	<p>20% coinsurance</p> <p>20% coinsurance</p> <p>20% coinsurance</p>	<p>40% coinsurance</p> <p>40% coinsurance</p> <p>40% coinsurance</p>

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency and Urgent Care		
Emergency room facility services	20% coinsurance	Covered as In-Network
Emergency room doctor and other services	20% coinsurance	Covered as In-Network
Ambulance (air and ground)	20% coinsurance	Covered as In-Network
Urgent Care (physician services)	20% coinsurance	40% coinsurance
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Facility visit: Facility fees	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Surgery		
Facility fees:		
Hospital <i>Subject to utilization review. Coverage for Out-of-Network Provider is limited to \$350 maximum per admission.</i>	20% coinsurance	40% coinsurance
Freestanding Surgical Center <i>Coverage for Out-of-Network Provider is limited to \$350 maximum per admission. Certain surgeries are subject to utilization review.</i>	20% coinsurance	40% coinsurance
Doctor and other services	20% coinsurance	40% coinsurance
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)		
Facility fees (for example, room & board) <i>Subject to utilization review (waived for emergency admission). Coverage for Out-of-Network Provider is limited to \$1,000 maximum per day for non-emergency admission.</i>	20% coinsurance	40% coinsurance
Doctor and other services	20% coinsurance	40% coinsurance

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Recovery & Rehabilitation Home health care <i>Coverage for In-Network Provider and Non-Network Provider combined is limited to 100 visits per calendar year.</i>	20% coinsurance	40% coinsurance
Rehabilitation services (for example, physical/speech/occupational therapy): Office Outpatient hospital Habilitation services	20% coinsurance 20% coinsurance 20% coinsurance	40% coinsurance 40% coinsurance 40% coinsurance
Cardiac rehabilitation Office Outpatient hospital	20% coinsurance 20% coinsurance	40% coinsurance 40% coinsurance
Skilled nursing care (in a facility) <i>Subject to utilization review. Coverage for In-Network Provider and Non-Network Provider combined is limited to 100 days per calendar year.</i>	20% coinsurance	40% coinsurance
Hospice	20% coinsurance	40% coinsurance
Durable Medical Equipment	50% coinsurance	50% coinsurance
Prosthetic Devices	20% coinsurance	40% coinsurance
Hemodialysis in an Outpatient facility <i>Coverage for Out-of-Network Provider is limited to \$350 maximum per visit for free standing hemodialysis center.</i>	20% coinsurance	40% coinsurance
Home Infusion Therapy <i>Subject to utilization review. Coverage for Out-of-Network Provider is limited to \$600 maximum per day.</i>	20% coinsurance	40% coinsurance

Your summary of benefits

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 deductible	Combined with medical deductible
Prescription Drug Coverage <i>This plan uses the National Formulary Drug list.</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 on all tiers for retail fills that exceed 30 days. Includes diabetic supplies.</i>	20% coinsurance (retail and home delivery)	40% coinsurance (retail only)
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>	20% coinsurance (retail and home delivery)	40% coinsurance (retail only)
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). Includes compound drugs (retail only).</i>	20% coinsurance (retail and home delivery)	40% coinsurance (retail only)
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>	20% coinsurance of prescription drug maximum allowed amount (retail and home delivery)	40% coinsurance (retail only)

Your summary of benefits

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 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.
- 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.
- Pharmacy deductible and pharmacy out of pocket is combined with medical deductible and out-of-pocket.
- This 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 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.
- 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.

Your summary of benefits

- 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
- Preferred Generic Program: If a member requests a brand name drug when a generic drug version exists, the member pays the generic drug copay plus the difference in cost between the prescription drug maximum allowed amount for the generic drug and the brand name drug dispensed, but not more than 50% of our average cost of that type of prescription drug. The Preferred Generic Program does not apply when the physician has specified "dispense as written" (DAW) or when it has been determined that the brand name drug is medically necessary for the member. In such case, the applicable copay for the dispensed drug will apply.
- 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
- 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.

Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Questions: (855) 333-5730 or visit us at www.anthem.com/ca
CA/L/F/CDHP/LL2103/NA/01-19 (HSA Green Plan) -C