Your summary of benefits

Anthem Blue Cross

County of San Luis Obispo

Your Plan: EPO Medicare COB

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	$0 single / $0 family	$0
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 / $3,000 family	$0
Preventive care/screening/immunization	No charge	Not covered
Doctor Home and Office Services		
Primary care visit to treat an injury or illness	$15 copay per visit	Not covered
Specialist care visit	$15 copay per visit	Not covered
Prenatal and Post-natal Care	$15 copay per visit	Not covered
Other practitioner visits:		
Retail health clinic	$15 copay per visit	Not covered
On-line Visit	$15 copay per visit	Not covered
Chiropractor services *Coverage for Chiropractor and Acupuncture services is limited to 20 visit limit per benefit period combined.*	$15 copay per visit	Not covered
Acupuncture *Coverage for Chiropractor and Acupuncture services is limited to 20 visit limit per benefit period combined.*	$15 copay per visit	Not covered

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Other services in an office:		
Allergy testing	No charge	Not covered
Chemo/radiation therapy	No charge	Not covered
Hemodialysis	No charge	Not covered
Prescription drugs *For the drugs itself dispensed in the office thru infusion/injection*	No charge	Not covered
Diagnostic Services		
Lab:		
Office	No charge	Not covered
Freestanding Lab	No charge	Not covered
Outpatient Hospital	No charge	Not covered
X-ray:		
Office	No charge	Not covered
Freestanding Radiology Center	No charge	Not covered
Outpatient Hospital	No charge	Not covered
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office	No charge	Not covered
Freestanding Radiology Center	No charge	Not covered
Outpatient Hospital	No charge	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.*	$50 copay per visit	Covered as In-Network
Emergency room doctor and other services	No charge	Covered as In-Network
Ambulance (air and ground)	No charge	Not covered

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Urgent Care (office setting)	$15 copay per visit	Not covered
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit	$15 copay per visit	Not covered
Facility visit:		
Facility fees	No charge	Not covered
Outpatient Surgery		
Facility fees:		
Hospital	No charge	Not covered
Freestanding Surgical Center	No charge	Not covered
Doctor and other services	No charge	Not covered
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)		
Facility fees (for example, room & board)	No charge	Not covered
Doctor and other services	No charge	Not covered
Recovery & Rehabilitation		
Home health care	No charge	Not covered
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office	No charge	Not covered
Outpatient hospital	No charge	Not covered
Habilitation services	No charge	Not covered
Cardiac rehabilitation		
Office	No charge	Not covered
Outpatient hospital	No charge	Not covered

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Skilled nursing care (in a facility)	No charge	Not covered
Hospice	No charge	Not covered
Durable Medical Equipment	No charge	Not covered
Prosthetic Devices	No charge	Not covered
Vision Services *Examinations are limited to one and lenses are limited to two during a Calendar Year. Frames are limited to one set over a two-year period.* *When the Member chooses contact lenses instead of other eyewear, payment is limited to the combined allowance for frames and lenses as specified, but not to exceed $100.00.*	**Allowance** Complete eye examination $35.00 Lens (each): Single vision ..... $20.00 Bifocal ..... $35.00 Trifocal ..... $45.00 Lenticular..... $50.00 Contact lenses..... $100.00 Frames..... $30.00	Same as In-Network
Hearing Aids *Limited to $2,000 maximum once every 24 months.*	20%	20%

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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).
- 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.
- Annual Out-of-Pocket Maximums includes deductible, copays, and coinsurance.
- 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.
- 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.
- 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.
- Skilled Nursing Facility day limit does not apply to mental health and substance abuse.
- Respite Care limited to 5 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