Your summary of benefits

Anthem BlueCross

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County of San Luis Obispo

Your Plan: Custom Premier PPO 500/20/20 (Select Basic Plan)

Your Network: Select 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 *See notes section to understand how your deductible works. In-Network Providers and Non-Network Providers deductibles are combined. Satisfying one helps satisfy the other.*	$500 single / $1,000 family	$500 single / $1,000 family
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.*	$3,000 single / $6,000 family	No limit single / No limit family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	40% coinsurance
Doctor Home and Office Services		
Primary care visit to treat an injury or illness *Deductible does not apply to In-Network providers.*	$20 copay per visit	40% coinsurance
Specialist care visit *Deductible does not apply to In-Network providers.*	$20 copay per visit	40% coinsurance
Prenatal and Post-natal Care	$20 copay per visit	40% coinsurance
Other practitioner visits:		
Retail health clinic *Deductible does not apply to In-Network providers.*	$20 copay per visit	40% coinsurance
On-line Visit *Deductible does not apply to In-Network providers.*	$20 copay per visit then 20% of all other charges	40% coinsurance

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Chiropractor services *Coverage for In-Network Provider and Non-Network Provider combined is limited to 20 visits per benefit period combined with Acupuncture visits. Deductible does not apply to In-Network providers.*	$15 copay per visit	40% coinsurance
Acupuncture *Coverage for In-Network Provider and Non-Network Provider combined is limited to 20 visits per benefit period combined with Chiropractor visits. Deductible does not apply to In-Network providers.*	$15 copay per visit	40% coinsurance
Other services in an office:		
Allergy testing	20% coinsurance	40% coinsurance
Chemo/radiation therapy	20% coinsurance	40% coinsurance
Hemodialysis	20% coinsurance	40% coinsurance
Prescription drugs *For the drugs itself dispensed in the office thru infusion/injection*	20% coinsurance	40% coinsurance
Diagnostic Services		
Lab:		
Office	20% coinsurance	40% coinsurance
Freestanding Lab	20% coinsurance	40% coinsurance
Outpatient Hospital	20% coinsurance	40% coinsurance
X-ray:		
Office	20% coinsurance	40% coinsurance
Freestanding Radiology Center	20% coinsurance	40% coinsurance
Outpatient Hospital	20% coinsurance	40% coinsurance
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office	20% coinsurance	40% coinsurance
Freestanding Radiology Center	20% coinsurance	40% coinsurance
Outpatient Hospital	20% coinsurance	40% coinsurance

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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 and then 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 (office setting) *Deductible does not apply to In-Network providers.*	$20 copay per visit	40% coinsurance
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit *Deductible does not apply to In-Network providers.*	$20 copay per visit	40% after deductible is met.
Facility visit:		
Facility fees	20% coinsurance after deductible is met.	40% after deductible is met.
Outpatient Surgery		
Facility fees:		
Hospital	20% coinsurance	40% coinsurance
Freestanding Surgical Center *Coverage for Out-of-Network Provider is limited to $350 maximum per visit.*	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)	20% coinsurance	40% coinsurance
Doctor and other services	20% coinsurance	40% coinsurance

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Recovery & Rehabilitation		
Home health care *Coverage for In-Network Provider and Non-Network Provider combined is limited to 45 visit limit per calendar year.*	20% coinsurance	40% coinsurance
Rehabilitation services (for example, physical/ occupational therapy): *Coverage for In-Network Provider and Non-Network Provider combined is limited to 24 visits per calendar year for Physical Therapy and Occupational Therapy. Additional visits may be authorized if medically necessary. Occupational Therapy visits are 20% coinsurance for all providers.*		
Office *Costs may vary by site of service.*	20% coinsurance	40% coinsurance
Outpatient hospital	20% coinsurance	40% coinsurance
Habilitation services	20% coinsurance	40% coinsurance
Cardiac rehabilitation *Coverage for In-Network Provider and Non-Network Provider combined is limited to 40 visits per calendar year.*		
Office	20% coinsurance	40% coinsurance
Outpatient hospital	20% coinsurance	40% coinsurance
Skilled nursing care (in a facility) *Coverage for In-Network Provider and Non-Network Provider combined is limited to 100 day limit per calendar year.*	Days 1 – 10: 20% coinsurance; Days 11 – 100: 30% coinsurance	40% coinsurance
Hospice	20% coinsurance	20% coinsurance
Durable Medical Equipment	20% coinsurance	40% coinsurance
Prosthetic Devices	20% coinsurance	40% coinsurance
Speech Therapy *Coverage for In-Network Provider and Non-Network Provider combined is limited to 24 visits per calendar year.*	20% coinsurance	40% coinsurance

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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, and coinsurance.
- In network and out of network out of pocket maximum are exclusive of each other.
- 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.
- 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 an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- 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.
- When using Non-PPO and Other Health Care Providers, members are responsible for any difference between the covered expense '&' actual charges, as well as any deductible '&' percentage copay.
- 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.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.
- Bariatric Surgery travel benefits are limited to: Transportation to and from the designated CME for the Member, up to 3 trips (one pre-surgical visit, the initial surgery and one follow-up visit) per authorized bariatric surgical procedure, not to exceed $130 per trip. Transportation to and from the designated CME for one companion, up to 2 trips (the initial surgery and one follow-up visit), not to exceed $130 per trip. (Only if the companion travels separately from the Member.) One room double occupancy hotel accommodations for the Member and one companion for the pre-surgical and follow-up visits, up to 2 days per trip, not to exceed $100 per day. One room double occupancy hotel accommodations for the companion during the Member's initial surgery Stay, up to 4 days, not to exceed $100 per day. (Only if the companion stays in a separate room from the Member.) Other necessary expenses, such as meals, are limited to a combined total of $25 per day, up to 4 days per trip.
- 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
- 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_PPO
- 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.