County of Sonoma: County Health Plan-EPO Medical Plan

Coverage Period: 06/01/2015 – 05/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual + Family | Plan Type: EPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.hr.sonoma-county.org or by calling County Employee Benefits at (707) 565-2900 or Anthem at (800) 759-3030.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500**/person; **$1,500**/family per coverage period (meaning 6-1-15 to 5-31-16). Does not apply to preventive care, office visits to in-network EPO providers, and outpatient prescription drugs. Copayments and non-covered expenses do not count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes, the limit for medical plan cost-sharing including deductibles, copayments and coinsurance is **$5,500**/person; **$11,500**/family per coverage period (meaning 6-1-15 to 5-31-16). The limit for outpatient prescription drug cost-sharing including copayments is **$1,100** per person; **$1,700** family per coverage period (meaning 6-1-15 to 5-31-16).	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you pay for health care expenses.
What is not included in the out–of–pocket limit?	The medical plan **out-of-pocket limit** does not accumulate premiums, balance-billed charges, non-covered expenses, charges in excess of benefit maximums and allowed charges, a penalty for failure to obtain precertification and outpatient retail/mail order prescription drug expenses. The outpatient prescription drug **out-of-pocket limit** does not accumulate premiums, balance-billed charges, non-covered expenses, charges in excess of benefit maximums and allowed charges, medical plan expenses or a penalty for failure to obtain precertification.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.

Does this plan use a network of providers?	Yes. For a list of **in-network EPO providers in the Prudent Buyer Plan within California, see Anthem Blue Cross at their website:** http://www.anthem.com/ca or call (800) 759-3030. **Network providers for outside of California**, see http://www.bluecares.com and select Blue Cross PPO (Prudent Buyer) or call (800) 759-3030. **Except for emergencies, services received outside of the Anthem Blue Cross PPO or Bluecard networks are not covered and participants will be responsible for all costs incurred.**	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred** or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network EPO **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$50 copayment per visit, no deductible applies.	No coverage.	Organ and tissue transplants require preauthorization to avoid reducing Plan's payment by 50%.
	Specialist visit	$50 copayment per visit, no deductible applies.	No coverage.	Organ and tissue transplants require preauthorization to avoid reducing Plan's payment by 50%.
	Other practitioner office visit	Acupuncture and Chiropractic Services: 20% coinsurance after deductible met.	No coverage.	---none---

Common Medical Event	Services You May Need	Your Cost If You Use an In Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
	Preventive care/screening/ immunization	Preventive Care, preventive/screening lab and x-ray services, and Immunizations: No charge.	No coverage.	Plan covers preventive services and supplies required by the Health Reform law. Age and frequency guidelines apply to covered preventive care. Covered services include: an annual preventive care exam, colonoscopy as ordered by your physician, annual pap smear, & mammogram. Hepatitis B immunizations require preauthorization to avoid non-payment of expenses.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible met.	No coverage.	---none---
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible met.	No coverage.	---none---
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available from CVS Caremark at www.caremark.com or call 1(800) 966-5772.	Generic drugs	Retail Pharmacy for 34-day supply: $10 copayment; Mail Order for 90-day supply: $10 copayment. FDA-approved Contraceptives: No charge for generic drugs.	You pay 100% and later can send CVS Caremark your prescription drug claim. You will be reimbursed the same amount had you filled the prescription using an In-Network Retail pharmacy.	For maintenance drugs, after two fills at retail, mail order is mandatory. You pay the lesser of the copayment or the drug cost. Some prescriptions are subject to preapproval and/or quantity limit requirements. The **out-of-pocket limit on outpatient drugs** is the most you pay for covered generic, preferred brand, non-preferred brand & specialty drugs from in-network retail & mail order locations per calendar year and is **$1,100/person; $1,700/family** (these amounts will be adjusted in accordance with law). Out-of-Network drugs and the difference in price between generic and brand drug costs if a brand drug is filled when a generic is available, do not accumulate to this **out-of-pocket limit.**

Common Medical Event	Services You May Need	Your Cost If You Use an In Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
	Preferred brand drugs	Retail Pharmacy for 34-day supply: $35 copayment; Mail Order for 90-day supply: $35 copayment. FDA-approved Contraceptives: No charge for preferred brand drug if generic drug is medically inappropriate.		This plan has a mandatory generic drug program so if you purchase a brand drug when generic drug is available you pay a higher cost. You pay the lesser of the copayment or the drug cost. Some prescriptions are subject to preapproval and/or quantity limit requirements.
	Non-preferred brand drugs	Retail Pharmacy for 34-day supply: $70 copayment; Mail Order for 90-day supply: $70 copayment.		If you purchase a brand drug when generic drug is available you pay a higher cost. You pay the lesser of the copayment or the drug cost. Some prescriptions are subject to preapproval and/or quantity limit requirements.
	Specialty drugs	For up to a 30-day supply you pay the same copays as noted above under generic, preferred brand or non-preferred brand drugs.	No coverage.	Specialty drugs require preapproval by calling CVS Caremark at 866-387-2573.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible met and $500 copay if use a hospital-based ambulatory surgery center.	No coverage.	No copay if you use a free-standing ambulatory surgery center.
	Physician/surgeon fees	20% coinsurance after deductible met.	No coverage.	---none---
If you need immediate medical attention	Emergency room services	20% coinsurance after deductible met plus $150 copayment per visit.	For an emergency: 20% coinsurance after deductible met plus $150 copayment/visit.	Copayment waived if admitted as inpatient.
	Emergency medical transportation	20% coinsurance after deductible met.	No coverage.	For non-emergency ambulance transport out of network, your coinsurance increases to 40%.

Common Medical Event	Services You May Need	Your Cost If You Use an In Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
	Urgent care	$50 copayment per visit, no deductible applies.	No coverage.	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible met and $500 copay per admission.	No coverage.	All non-emergency inpatient confinements including organ and tissue transplants require preauthorization to avoid reducing Plan's payment by 50%.
	Physician/surgeon fee	20% coinsurance after deductible met.	No coverage.	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Non-physician: 20% coinsurance after deductible met. Physician: $50 copay per visit, deductible waived.	No coverage.	Covered outpatient non-physician providers include psychologist, Marriage & Family Therapy (MFT) or Licensed Clinical Social Worker (LCSW). You pay 100% for marriage counseling.
	Mental/Behavioral health inpatient services	20% coinsurance after deductible met and $500 copay per admission.	No coverage.	All non-emergency inpatient confinements require preauthorization to avoid reducing Plan's payment by 50%.
	Substance use disorder outpatient services	20% coinsurance after deductible met.	No coverage.	---none---
	Substance use disorder inpatient services	20% coinsurance after deductible met and $500 copay per admission.	No coverage.	All non-emergency inpatient confinements require preauthorization to avoid reducing Plan's payment by 50%.
If you are pregnant	Prenatal and postnatal care	Office Visits for all females: No charge. Delivery Fees: 20% coinsurance after deductible met.	No coverage.	You pay 100% for non-office visit services for maternity care (like ultrasounds) and delivery expenses for dependent daughters.
	Delivery and all inpatient services	Hospital: 20% coinsurance after deductible met and $250 copay per admission. Physician: 20% coinsurance after deductible met.	No coverage.	Preauthorization required only if hospital stay is more than 48 hours for vaginal delivery or 96 hours for C-section. You pay 100% for non-office visit services for maternity care (like ultrasounds) and delivery expenses for dependent daughters.

Common Medical Event	Services You May Need	Your Cost If You Use an In Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No coverage.	No coverage.	You pay 100% coinsurance for home health care.
	Rehabilitation services	Physical, Occupational, and Speech Therapy outpatient visits: 20% coinsurance after deductible met.	No coverage.	You pay 100% of the cost of occupational therapy, except when provided by a home health agency, hospice or home infusion therapy provider.
	Habilitation services	No coverage.	No coverage.	You pay 100% of these expenses.
	Skilled nursing care	No coverage.	No coverage.	---none---
	Durable medical equipment	20% coinsurance after deductible met.	No coverage.	Equipment over $1,000 per item requires preauthorization to avoid non-payment of expenses.
	Hospice service	20% coinsurance after deductible met.	No coverage.	---none---
If your child needs dental or eye care	Eye exam	No charge if occurs during a preventive care office visit.	No coverage.	Covered for children up to 26 yrs.
	Glasses	No coverage.	No coverage.	You pay 100% of these expenses.
	Dental check-up	No coverage.	No coverage.	You pay 100% of these expenses.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult) (Child)
- Habilitation services
- Home health care services
- Infertility treatment (beyond diagnostic services and surgical repair)
- Long-term care
- Marriage counseling
- Maternity/Delivery expenses. (You pay 100% for non-office visit services for maternity care (like ultrasounds) & delivery expenses for dependent daughters.)
- Non-emergency care when traveling outside the U.S.
- Occupational therapy (except when provided by a home health agency, hospice or home infusion therapy provider)
- Out-of-Network Providers are not covered except for an emergency situation
- Private duty nursing
- Routine eye care (Adult) (Child) plus eyeglasses
- Routine foot care
- Skilled Nursing care/skilled nursing facility
- Weight loss programs

Other Covered Services
(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric Surgery (when medically necessary)
- Chiropractic care.
- Hearing aids (one per ear every 36 months)
- Infertility treatment (diagnostic services and surgical repair only)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at County Employee Benefits at (707) 565-2900 or email us at benefits@sonoma-county.org. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the County Employee Benefits at (707) 565-2900 or email us at benefits@sonoma-county.org or contact Anthem at (800) 759-3030.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This Plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al (800) 759-3030. Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 759-3030. Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** (800) 759-3030.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,430
- **Patient pays** $2,110

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$520
Coinsurance	$1,060
Limits or exclusions	$30
Total	**$2,110**

Managing type 2 diabetes
(routine maintenance of a well controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,740
- **Patient pays** $1,660

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$500
Copays	$900
Coinsurance	$180
Limits or exclusions	$80
Total	**$1,660**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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Questions: Call County Employee Benefits at (707) 565-2900 or email us at benefits@sonoma-county.org or call Anthem at (800) 759-3030 or visit us at **www.hr.sonoma-county.org**. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.hr.sonoma-county.org** or www.cciio.cms.gov or call County Employee Benefits at (707) 565-2900 to request a copy.