County of Sonoma

2024 Summary of Benefits

PPO Plan 0PH

Anthem.com/CA

About this plan:

Anthem BC Health Insurance Company gives you the tools and resources to make the best decisions for your health, like this summary of benefits. It's a snapshot of your plan's covered benefits and services and what they cost. This Summary of Benefits doesn't list every service we cover or every limitation or exclusion. For more details about your benefits and services, please review your *Evidence of Coverage* (EOC). You can access your EOC online by logging into the member portal, or you can call Member Services with any questions you may have.

Doctor and hospital choice: You may go to doctors, specialists, and hospitals in or out of the network. You do not need a referral.

This plan offers coverage in our Centers for Medicare & Medicaid Services (CMS) defined geographic service area of all 50 states, Washington, DC, and all United States territories.

How much is the monthly premium?	Contact your group plan benefit administrator to determine your actual premium amount, if applicable.

Questions?

Call our **First Impressions Welcome Team** for answers or plan details.

1-833-848-8730 (TTY: **711**) **Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays**

Anthem Medicare Preferred (PPO) Benefits Effective: 6/1/2024 - 12/31/2024

	In-network:	Out-of-network:
Annual medical deductible:	$0 Combined in-network and out-of-network	
Maximum out-of-pocket responsibility: (Does not include Part D prescription drugs)	$0 Combined in-network and out-of-network	

Covered medical benefits	In-network, members pay:	Out-of-network, members pay:
Inpatient hospital care*	For Medicare-covered hospital stays: $0 copay per admission	For Medicare-covered hospital stays: $0 copay per admission
Outpatient hospital facility or ambulatory surgical center visit for surgery*	$0 copay per visit	$0 copay per visit
Outpatient hospital services observation room	$0 copay per visit	$0 copay per visit
Primary care office visit	$0 copay per visit	$0 copay per visit
Specialty care office visit	$0 copay per visit	$0 copay per visit
Preventive care, screenings, and tests	$0 copay per visit	$0 copay per visit
Emergency care	$0 copay for each Medicare-covered emergency room visit	
Urgently needed services	$0 copay for each Medicare-covered urgently needed care visit	
X-ray visit and/or simple diagnostic test*	$0 copay per visit	$0 copay per visit
Complex diagnostic test and/or radiology visit*	$0 copay per visit	$0 copay per visit
Radiation therapy treatment*	$0 copay per visit	$0 copay per visit
Clinical/diagnostic lab test*	$0 copay per visit	$0 copay per visit
Medicare-covered basic hearing and balance exams performed by your specialist*	$0 copay per visit	$0 copay per visit

Covered medical benefits	In-network, members pay:	Out-of-network, members pay:
Routine hearing services	Must use a Hearing Care Solutions participating provider. $0 copay for routine hearing exams, one exam every calendar year combined in-network and out-of-network. $0 copay for hearing aid fitting evaluations, one evaluation per covered hearing aid combined in-network and out-of-network. Routine hearing exams and fitting evaluations are limited to a $70 maximum benefit every calendar year combined in-network and out-of-network. $0 copay for hearing aids Hearing aids are limited to a $500 benefit per ear with a $1,000 maximum benefit every three calendar years combined in-network and out-of-network.	Out-of-network providers must order hearing aids through Hearing Care Solutions. $0 copay for routine hearing exams, one exam every calendar year combined in-network and out-of-network. $0 copay for hearing aid fitting evaluations, one evaluation per covered hearing aid combined in-network and out-of-network. Routine hearing exams and fitting evaluations are limited to a $70 maximum benefit every calendar year combined in-network and out-of-network. $0 copay for hearing aids through Hearing Care Solutions Hearing aids are limited to a $500 benefit per ear with a $1,000 maximum benefit every three calendar years combined in-network and out-of-network through Hearing Care Solutions.
Medicare-covered dental is non-routine care performed by your specialist*	$0 copay per visit	$0 copay per visit
Medicare-covered exams performed by your specialist to diagnose and treat eye diseases and conditions	$0 copay per visit	$0 copay per visit
Medicare-covered glaucoma screening	$0 copay per visit	$0 copay per visit
Medicare-covered eyewear following cataract surgery	$0 copay per surgery	$0 copay per surgery

Covered medical benefits	In-network, members pay:	Out-of-network, members pay:
Routine vision eye exam	Must use a Blue View Vision provider. $0 copay for routine vision exams, one exam every calendar year, $70 maximum benefit every calendar year combined in-network and out-of-network.	$0 copay for routine vision exams, one exam every calendar year, $70 maximum benefit every calendar year combined in-network and out-of-network.
Routine vision eyewear	Must use a Blue View Vision provider. $0 copay for eyewear Eyewear is limited to a $100 maximum benefit every two calendar years combined in-network and out-of-network.	$0 copay for eyewear Eyewear is limited to a $100 maximum benefit every two calendar years combined in-network and out-of-network.
Inpatient services in a psychiatric hospital*	For Medicare-covered hospital stays: $0 copay per admission	For Medicare-covered hospital stays: $0 copay per admission
Mental health professional individual therapy visit	$0 copay per visit	$0 copay per visit
Substance abuse professional individual therapy visit	$0 copay per visit	$0 copay per visit
Skilled nursing facility (SNF) care*	For Medicare-covered SNF stays: $0 copay for days 1-100 per benefit period 100-day limit per benefit period	For Medicare-covered SNF stays: $0 copay for days 1-100 per benefit period 100-day limit per benefit period
Outpatient rehabilitation services*	$0 copay per visit	$0 copay per visit
Ambulance services	Your provider must get an approval from the plan before you get ground, air, or water transportation that is not an emergency. $0 copay per one-way trip for Medicare-covered ambulance services	

Covered medical benefits	In-network, members pay:	Out-of-network, members pay:
Routine Transportation Non-Emergency	$0 copay for routine transportation	
Medicare Part B prescription drugs*	$0 copay for Medicare-covered Part B drugs	$0 copay for Medicare-covered Part B drugs
Chiropractic services* Medicare-covered	$0 copay per visit	$0 copay per visit
Additional chiropractic services*	$0 copay per visit Medicare non-covered chiropractic services are limited to 20 visits per year combined in-network and out-of-network.	$0 copay per visit Medicare non-covered chiropractic services are limited to 20 visits per year combined in-network and out-of-network.
Acupuncture for chronic low back pain* Medicare-covered	$0 copay per visit	$0 copay per visit
Additional acupuncture services*	$0 copay per visit Medicare non-covered acupuncture services are limited to 20 visits per year combined in-network and out-of-network.	$0 copay per visit Medicare non-covered acupuncture services are limited to 20 visits per year combined in-network and out-of-network.
Cardiac rehabilitation services*	$0 copay per visit	$0 copay per visit
Pulmonary rehabilitation services*	$0 copay per visit	$0 copay per visit
Blood glucose test strips, lancets, lancet devices, and glucose control solutions	$0 copay for a 30-day supply on each Medicare-covered purchase of blood glucose test strips, lancets, lancet devices, and glucose control solutions	$0 copay for a 30-day supply on each Medicare-covered purchase of blood glucose test strips, lancets, lancet devices, and glucose control solutions
Blood glucose monitors	$0 copay for Medicare-covered blood glucose monitors	$0 copay for Medicare-covered blood glucose monitors
Therapeutic shoes	$0 copay per purchase	$0 copay per purchase
Diabetes self-management training	$0 copay per visit	$0 copay per visit
Continuous glucose monitors (CGMs)*	$0 copay per purchase	$0 copay per purchase
Durable medical equipment (DME) and related supplies*	$0 copay per purchase	$0 copay per purchase

Covered medical benefits	In-network, members pay:	Out-of-network, members pay:
Opioid treatment program services*	$0 copay per visit	$0 copay per visit
Podiatry services*	$0 copay per visit	$0 copay per visit
Routine foot care	$0 copay per visit, 12 visits per year combined in-network and out-of-network	$0 copay per visit, 12 visits per year combined in-network and out-of-network
Home health agency care*	$0 copay per visit	$0 copay per visit
Hospice care When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and B services are paid for by Original Medicare, not this plan.	$0 copay for the one time only hospice consultation One visit per lifetime	$0 copay for the one time only hospice consultation One visit per lifetime

Additional covered benefits and services	Members pay:
Video doctor visits LiveHealth Online†	$0 copay for video doctor visits using LiveHealth Online
Health and wellness programs SilverSneakers® Membership† Take fitness classes virtually or visit a participating location.	$0 copay for the SilverSneakers fitness benefit
24/7 NurseLine†	$0 copay for 24/7 NurseLine
Foreign travel emergency (outside U.S. territories) Emergency care Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months	$0 copay for emergency care
Foreign Travel - Urgently Needed Services	$0 copay for urgently needed services
Foreign Travel - Inpatient Care	$0 copay per admission for emergency inpatient care 60 days per lifetime
Healthy Meals†* Meals delivered after being discharged from inpatient hospital visit or for members living with a chronic condition	$0 copay for Healthy Meals Provides up to 14 meals per qualifying event, allows up to four (4) events each year (56 meals in total).
Adult day center*	$0 copay for each adult day center visit
Assistive devices†	This plan provides a $200 annual spending allowance toward covered assistive devices. Unused allowance amounts do not roll over to the next benefit year.
Health and fitness tracker for your body and mind health†	$0 copay for health and fitness tracker
Personal emergency response system (PERS)†	$0 copay for personal emergency response system
Medicare Community Resource Support	$0 copay for Medicare Community Resource Support

* Some services that fall within this benefit category require prior authorization. Based on the service you are receiving, your provider will know if prior authorization is needed. This means an approval in advance

is needed, by your plan, to get covered services. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other in-network provider gets prior authorization from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, we recommend you ask for a pre-visit coverage decision to confirm that the services you are getting are covered and medically necessary. Benefit categories that include services that require prior authorization are marked with an asterisk in the benefits chart.

Note: While you can get your care from an out-of-network provider for Medicare-covered services, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If the provider is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Providers that do not contract with us are under no obligation to treat you, except in emergency situations.

This document reflects cost shares only.

†Must use the plan approved provider

Some of the benefits and limitations listed above are combined in-network and out-of-network.

This information is not a complete description of the benefits. Contact the plan for more information. Limitations, copayments, coinsurance, and restrictions may apply. If there is a difference between this document and the *Evidence of Coverage* (EOC), the EOC is considered correct.

Some of the benefits mentioned are part of a special supplement program for the chronically ill. Not all members may qualify for these benefits.

Benefits, premiums and/or copayments/coinsurance may change upon renewal or on January 1 of each year.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our member service number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service.

Medicare & You 2024 resource: For more information, we encourage you to read Medicare & You 2024. This booklet is mailed to people with Medicare every year in the fall. It has a summary of Medicare benefits, rights, and protections. It also includes answers to the most frequently asked questions. If you don't have a copy of this booklet, request one at **www.medicare.gov.** Or call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**.

LiveHealth Online is the trade name of Carelon Health, Inc., a separate company, providing telehealth services on behalf of the plan.

The SilverSneakers fitness program is provided by Tivity Health, an independent company. SilverSneakers is a registered trademark of Tivity Health, Inc.

Anthem BC Health Insurance Company is an LPPO plan with a Medicare contract. Enrollment in Anthem BC Health Insurance Company depends on contract renewal. Anthem BC Health Insurance Company is the trade name of Anthem Insurance Companies, Inc. Independent licensee of the Blue Cross Association.

Prescription Drug Summary of Benefits: 6/1/2024 – 12/31/2024

Formulary E3, 5/10/10 (with Senior Rx Plus)

Stage 1 Annual Deductible Stage

In this stage, you pay a set amount. Once you reach this amount, your plan begins to pay its share of the cost.

Deductible: $0

Stage 2 Initial Coverage Stage

Below is your payment responsibility until the amount paid by you and the Coverage Gap Discount Program for covered Part D prescriptions reaches your True Out of Pocket limit of $8,000.

Retail Pharmacy	Standard Network Pharmacy		Mail-Order Pharmacy
	per 30-day supply	per 90-day supply	per 90-day supply
Tier 1: Select Generics	$0	$0	$0
Tier 1: Generics	$5	$15	$10
Tier 2: Preferred Brands	$10	$30	$20
Tier 3: Non-Preferred Drugs, including Specialty Drugs (Specialty limited to a 30-day supply)	$10	$30	$20

Stage 3 Catastrophic Coverage Stage

Your payment responsibility changes after the cost you and the Coverage Gap Discount Program have paid for covered drugs reaches your True Out of Pocket limit of $8,000.

Retail and Mail-Order Pharmacies	Up to a 90-day supply (Specialty limited to a 30-day supply)
Tier 1: Select Generics	$0
Tier 1: Generics	$0
Tier 2: Brand-Name Drugs	$0

- **Important Message About What You Pay for Vaccines:** All Advisory Committee on Immunization Practices (ACIP) recommended Part D vaccines are covered at no cost to you.
- **Important Message About What You Pay for Insulin:** You won't pay more than $35 for a one month supply of each insulin product covered by your plan, no matter what cost-sharing tier it is on.

Extra Covered Drugs Benefits Chart

These are prescription drugs that are covered by your retiree drug plan that are often excluded from Part D coverage. These prescription drugs are covered by your Senior Rx Plus benefits. Some of these drugs may be required on your retiree drug plan by state regulations. These drugs do not count towards your deductible or True Out of Pocket expenses. They do not qualify for lower Catastrophic copays.

Pharmacy	Retail Pharmacy per 30-day supply	Mail-Order Pharmacy per 90-day supply
Cough and Cold **DESI** **Vitamins and Minerals**	See Drug List for complete list of drugs covered	
Tier 1: Generics	$5	$10
Tier 2: Preferred Brands	$10	$20
Tier 3: Non-Preferred Drugs	$10	$20
Erectile Dysfunction (ED)	Immediate dose ED drugs Immediate dose formats are limited to 6 per 30 days.	
Tier 1: Generics	$5	$10
Tier 2: Preferred Brands	$10	$20
Tier 3: Non-Preferred Drugs	$10	$20
Other Non-Part D Coverage	Copay or coinsurance	
Contraceptive Devices	$10	$10

- **Over the Counter Drugs:** To get over the counter drugs listed as covered under your drug plan, you must have a prescription from your provider and have the prescribed drug filled by the pharmacist.

This document reflects cost shares only.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, coinsurance, and restrictions may apply.

Benefits, premiums and/or copayments/coinsurance may change upon renewal or on January 1 of each year.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Out-of-network/non-contracted providers are under no obligation to treat members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.

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