County of Sonoma

2025 Summary of Benefits

PPO Plan 0PH

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 at **www.anthem.com/CA**, 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 sponsor/union for more information on your plan premium.

Anthem Medicare Preferred (PPO) Benefits Effective: 06/01/2025 – 05/31/2026

Plan Features	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 benefits	In-network, members pay:	Out-of-network, members pay:
Inpatient hospital care* No limit to the number of days covered by the plan	$0 copay per admission	$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 per visit	
Urgently needed services	$0 copay per 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

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Medicare-covered basic hearing and balance exams performed by your specialist*	$0 copay per visit	$0 copay per visit
Routine hearing services We have partnered with Hearing Care Solutions to bring you these discounts and services.	Must use a Hearing Care Solutions participating provider. **Hearing exams** $0 copay for routine hearing exams 1 exam every calendar year combined in-network and out-of-network **Hearing aids fitting evaluation** $0 copay for hearing aid fitting evaluations 1 evaluation per covered hearing aid combined in-network and out-of-network **Routine hearing exams and fitting evaluations limit** $70 maximum benefit every calendar year combined in-network and out-of-network **Hearing aids** $0 copay for hearing aids $500 benefit per ear with a $1,000 maximum benefit every three calendar years	Out-of-network providers must order hearing aids through Hearing Care Solutions. **Hearing exams** $0 copay for routine hearing exams 1 exam every calendar year combined in-network and out-of-network **Hearing aids fitting evaluation** $0 copay for hearing aid fitting evaluations 1 evaluation per covered hearing aid combined in-network and out-of-network **Routine hearing exams and fitting evaluations limit** $70 maximum benefit every calendar year combined in-network and out-of-network **Hearing aids** $0 copay for hearing aids through Hearing Care Solutions $500 benefit per ear with a $1,000 maximum benefit every three calendar years
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

Covered benefits	In-network, members pay:	Out-of-network, members pay:
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
Routine vision services	Must use a Blue View Vision provider. **Exams** $0 copay for routine vision exams 1 exam every calendar year combined in-network and out-of-network **Eyewear** $0 copay for eyewear $100 maximum benefit every two calendar years combined in-network and out-of-network	**Exams** $70 reimbursement for routine vision exams 1 exam every calendar year combined in-network and out-of-network **Eyewear** $100 reimbursement for eyewear, maximum benefit every two calendar years combined in-network and out-of-network
Inpatient services in a psychiatric hospital* No limit to the number of days covered by the plan	$0 copay per admission	$0 copay per admission
Mental health professional individual therapy visit	$0 copay per visit	$0 copay per visit
Substance use disorder professional individual therapy visit	$0 copay per visit	$0 copay per visit
Skilled nursing facility (SNF) care*	$0 copay for days 1-100 per benefit period 100-day limit per benefit period	$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

Covered benefits	In-network, members pay:	Out-of-network, members pay:
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 ambulance services	
Routine Transportation Non-Emergency	$0 copay for routine transportation 12 one-way trips each year	
Medicare Part B prescription drugs*	$0 copay for Part B drugs	$0 copay for Part B drugs
Chiropractic services* Medicare-covered	$0 copay per visit	$0 copay per visit
Additional chiropractic services*	$0 copay per visit 20 visits per year combined in-network and out-of-network for additional chiropractic services	$0 copay per visit 20 visits per year combined in-network and out-of-network for additional chiropractic services
Acupuncture for chronic low back pain* Medicare-covered	$0 copay per visit	$0 copay per visit
Additional acupuncture services*	$0 copay per visit 20 visits per year combined in-network and out-of-network for additional acupuncture services	$0 copay per visit 20 visits per year combined in-network and out-of-network for additional acupuncture services
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 For a 30 day supply	$0 copay per purchase	$0 copay per purchase
Blood glucose monitors	$0 copay per purchase	$0 copay per purchase
Therapeutic shoes	$0 copay per purchase	$0 copay per purchase
Diabetes self-management training	$0 copay per visit	$0 copay per visit

Covered benefits	In-network, members pay:	Out-of-network, members pay:
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
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 consultation 1 visit per lifetime	$0 copay for the one time only consultation 1 visit per lifetime

Additional covered benefits and services	Member pays unless specified:
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	**Emergency care** $0 copay for emergency care
Foreign Travel - Urgently Needed Services Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months	**Urgently needed services** $0 copay for urgently needed services
Foreign Travel - Inpatient 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	**Inpatient care** $0 copay per admission 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 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, reimburse up to $80 for 1 day per week (up to 8 hours per day)
Assistive devices† Unused allowance amounts do not roll over to the next benefit year.	$200 annual spending allowance on your Benefits Prepaid Card toward covered assistive devices

Additional covered benefits and services	Member pays unless specified:
Health and fitness tracker†	$0 copay for health and fitness tracker 1 device every two years
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.

This document reflects cost shares only.

†Must use the plan approved provider

§ The benefits mentioned are Special Supplemental Benefits for the Chronically Ill (SSBCI). You may qualify for SSBCI if you have a high risk for hospitalization and require intensive care coordination to manage chronic conditions such as Chronic Kidney Diseases, Chronic Lung Disorders, Cardiovascular Disorders, Chronic Heart Failure, or Diabetes. For a full list of chronic conditions or to learn more about other eligibility requirements needed to qualify for SSBCI benefits, please refer to Chapter 4 in the plan's Evidence of Coverage.

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.

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 2025 resource: For more information, we encourage you to read Medicare & You 2025. 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 offered through an arrangement with Amwell, a separate company, providing telehealth services on behalf of your health plan.

The SilverSneakers fitness program is provided by Tivity Health, an independent company. SilverSneakers is a registered trademark of Tivity Health, Inc.©2024 Tivity Health, Inc. All rights reserved

Prescription Drug Summary of Benefits: 06/01/2025 – 05/31/2026
Formulary E3, 5/10/10 (with Senior Rx Plus)

County of Sonoma

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How much is the monthly premium?:
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Prescription Drug Summary of Benefits: 06/01/2025 – 05/31/2026

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 for covered prescriptions reaches your Drug Plan Maximum Out of Pocket of $2,000.

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

Stage 3 Catastrophic Coverage Stage

Your payment responsibility changes after the cost you have paid for covered drugs reaches your Drug Plan Maximum Out of Pocket of $2,000.

Retail and Mail-Order Pharmacies	Up to a 90-day supply (Specialty limited to a 30-day supply)
All Part D Covered Prescription 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

Pharmacy	Retail Pharmacy	Mail-Order Pharmacy
	per 30-day supply	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 Drugs	$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 Drugs	$10	$20
Tier 3: Non-Preferred Drugs	$10	$20

Pharmacy	Retail Pharmacy	Mail-Order Pharmacy
	per 30-day supply	per 90-day supply
Other Non-Part D Coverage	Copay or coinsurance	
Contraceptive Devices	$10 per Covered Device	$10 per Covered Device

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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.

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