San Mateo Electrical Workers APPRENTICES Anthem Blue Cross PPO Self-Funded Plan Benefit Summary 2020–2021

	PPO PROVIDERS	OUT OF NETWORK
Deductible – Individual	$0	$500
Deductible – Family	$0	$1,000
Annual Out-of-Pocket Maximum	The out of pocket maximum is $1,250 per individual and $2,500 per family.	The out of pocket maximum is $4,500 per individual and $9,000 per family.
	Deductible and office visit copayments do not apply to the out of pocket maximum.	
Lifetime Maximum	None	None
BENEFITS FOR COVERED SERVICES		
PHYSICIAN SERVICES	PPO PROVIDERS	OUT OF NETWORK
Office visits	$20 COPAYMENT	$20 COPAYMENT
Hospital/Skilled Nursing visits	90%	60%
Specialists	$20 COPAYMENT	$20 COPAYMENT
Surgeon/Asst. Surgeon	90%	60%
Anesthesiologist	90%	60%
Diagnostic X-ray & Labs	90%	60%
PREVENTIVE CARE	PPO PROVIDERS	OUT OF NETWORK
Routine Physical Exam	90%	60%
Well Baby Care	100%	60%, Covered from birth to age 3
Immunizations	100%	60%, Covered from birth to age 3
HOSPITAL/SURGICAL SERVICES	PPO PROVIDERS	OUT OF NETWORK
Inpatient**	90%	60%
Outpatient	90%	60%
EMERGENCY SERVICES	PPO PROVIDERS	OUT OF NETWORK
Ambulance	90%	90%
Emergency Room	90% after $100 copay Waived if Admitted	60% after $100 copay Waived if Admitted
MATERNITY SERVICES	PPO PROVIDERS	OUT OF NETWORK
Hospital Benefits – Delivery**	90%	60%
Outpatient Physician Services	90%	60%
Surgical Services	90%	60%

PRESCRIPTION DRUGS	IN NETWORK ONLY
Retail Purchase *Limit of 2 fills per medication at a retail pharmacy, not to exceed 30-day supplies for each fill*	$10 Generic/$25 Preferred Brand/ $40 Non-Preferred Brand
Generic or Brand maximum amount	30-day supply
Save money with Mail Order!	Prescription Drugs are provided by US Rx-Care
Mail Order Purchase *Required for all maintenance medications, after 2 fills at a retail pharmacy, not to exceed 90-day supplies.*	$20 Generic and $50 Preferred Brand/ $80 Non-Preferred Brand
Generic *or* Brand maximum amount	90-day supply

IMPORTANT: The IBEW Local 617 drug plan requires utilization of the mail order pharmacy for medications taken on a long-term basis. Copayments increase twofold upon the third prescription fill for any medication not filled by the plan's mail order pharmacy. Copayments are reduced by one third for 90-day supplies obtained through the mail order pharmacy. All new (first time) prescriptions for long-term medications should first be filled at a local retail pharmacy for the first 2 fills, to evaluate efficacy and tolerability, before 90-day maintenance supplies are ordered through the mail order pharmacy.

SUBSTANCE ABUSE TREATMENT	PPO PROVIDERS	OUT OF NETWORK
For inpatient or outpatient services for substance abuse treatment, please contact United Administrative Services at (408) 288-4400.		
Hospital Benefits **	90%, max 30 days per calendar year	60%, max 30 days per calendar year
Outpatient Physician Services	90%*	60%*
MENTAL AND NERVOUS - Optum (excludes severe mental disorders)	PPO PROVIDERS	OUT OF NETWORK
Hospital Benefits **	90%, max 30 days per calendar year	60%, max 30 days per calendar year
Outpatient Physician Services	90%*	60%*
CHIROPRACTIC AND ACUPUNCTURE SERVICES	90%*	60%*
CONTINUED CARE SERVICES	PPO PROVIDERS	OUT OF NETWORK
Home Health Care	90%*	60%*
Skilled Nursing Facility**	Following discharge from an acute care facility, plan pays 90%	Following discharge from an acute care facility, plan pays 60%
PHYSICAL THERAPY	90%*	60%*
SPEECH THERAPY	90%*	60%*

* Note: There is a 30 visit per calendar year limit for these services.
** Note: Precertification of services is required for non-emergency hospital admissions.