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

	PPO PROVIDERS	OUT OF NETWORK
Deductible – Individual	$0	$250
Deductible – Family	$0	$500
Annual Out-of-Pocket Maximum	The out of pocket maximum is $1,500 per individual and $3,000 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	$15 COPAYMENT	$15 COPAYMENT
Hospital/Skilled Nursing visits	80%	60%
Specialists	$15 COPAYMENT	$15 COPAYMENT
Surgeon/Asst. Surgeon	80%	60%
Anesthesiologist	80%	60%
Diagnostic X-ray & Labs	80%	60%
PREVENTIVE CARE	PPO PROVIDERS	OUT OF NETWORK
Routine Physical Exam	100%	60%
Well Baby Care	100%, Covered from birth to age	60%, Covered from birth to age 3
Immunizations	100%, Covered from birth to age	60%, Covered from birth to age 3
HOSPITAL/SURGICAL SERVICES	PPO PROVIDERS	OUT OF NETWORK
Inpatient**	80%	60%
Outpatient	80%	60%
EMERGENCY SERVICES	PPO PROVIDERS	OUT OF NETWORK
Ambulance	80%	90%
Emergency Room	80% after $50 copay Waived if Admitted	60% after $50 copay Waived if Admitted
MATERNITY SERVICES	PPO PROVIDERS	OUT OF NETWORK
Hospital Benefits – Delivery**	80%	60%
Outpatient Physician Services	80%	60%
Surgical Services	80%	60%

PRESCRIPTION DRUGS	IN NETWORK ONLY
Deductible for Pharmacy Services	**$100 Deductible** Per Calendar Year, Per Member
Retail Purchase *Limit of 2 fills per medication at a retail pharmacy, not to exceed 30-day supplies for each fill*	$10 Generic/$15 Preferred Brand/ $30 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 $30 Preferred Brand/ $60 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 **	80%, max 30 days per calendar year	60%, max 30 days per calendar year
Outpatient Physician Services	80%*	60%*
MENTAL AND NERVOUS - Optum (excludes severe mental disorders)	PPO PROVIDERS	OUT OF NETWORK
Hospital Benefits **	90%, max 20 days per calendar year	60%, max 20 days per calendar year
Outpatient Physician Services	80%*	60%*
CHIROPRACTIC AND ACUPUNCTURE SERVICES	80%*	60%*
CONTINUED CARE SERVICES	PPO PROVIDERS	OUT OF NETWORK
Home Health Care	80%*	60%*
Skilled Nursing Facility**	Following discharge from an acute care facility, plan pays 80%	Following discharge from an acute care facility, plan pays 60%
PHYSICAL THERAPY	80%*	60%*
SPEECH THERAPY	80%*	60%*

* Note: There is a 20 visit per calendar year limit for these services.

** Note: Precertification of services is required for non-emergency hospital admissions.