Your summary of benefits

Anthem BlueCross

Your Plan: $400 Deductible PPO

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal contract of coverage. If there is a difference between this summary and the contract of coverage, the contract of coverage will prevail.

Covered Medical Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
Overall Deductible *See notes below to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Retail Prescription Drug Coverage section.*	Single: $400 Family: $800	Single: $2,500 Family: $5,000
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. Your copays, coinsurance and deductibles count toward your out-of-pocket limit.*	Single: $2,200 Family: $4,400	Single: $4,400 Family: $8,800
Doctor Home and Office Services		
Preventive care *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charges	40% after deductible
Primary care visit to treat an injury or illness *Includes initial visit to confirm pregnancy.*	$20 copay	40% after deductible
Specialist care visit	$40 copay	40% after deductible
Prenatal and post-natal visit	Covered in full after $20 copay for initial visit.	40% after deductible
Other practitioner visits:		
Retail health clinic	$20 copay	40% after deductible
Chiropractor services *Limited to 30 visits across outpatient and other professional visits. Combined in-network and out-of-network.*	$40 copay	40% after deductible
Other services in an office:		
Allergy testing	20% after deductible	40% after deductible
Chemo/radiation therapy	$40 copay	40% after deductible
Hemodialysis	$40 copay	40% after deductible
Prescription drugs	20%, subject to office visit copay	40% after deductible

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Covered Medical Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
Diagnostic Services		
Lab:		
Office	20% after deductible	40% after deductible
Freestanding lab	20% after deductible	40% after deductible
Outpatient hospital	20% after deductible	40% after deductible
X-ray:		
Office	20% after deductible	40% after deductible
Freestanding radiology center	20% after deductible	40% after deductible
Outpatient hospital	20% after deductible	40% after deductible
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office	20% after deductible	40% after deductible
Freestanding radiology center	20% after deductible	40% after deductible
Outpatient hospital	20% after deductible	40% after deductible
Emergency and Urgent Care		
Emergency room facility services	$150 copay, then 20% after deductible	Same as in-network
Emergency room doctor and other services	20% after deductible	Same as in-network
Ambulance (air and ground)	20% after deductible	Same as in-network
Urgent care (office setting)	$50 copay	40% after deductible
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit	$20 copay	40% after deductible
Facility visit:		
Facility fees	20% after deductible	40% after deductible
Doctor and other services	20% after deductible	40% after deductible

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Covered Medical Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
Outpatient Surgery		
Facility fee:		
Hospital	20% after deductible	40% after deductible
Freestanding surgical center	20% after deductible	40% after deductible
Doctor and other services	20% after deductible	40% after deductible
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)		
Facility fee (for example, room & board)	20% after deductible	40% after deductible
Doctor and other services	20% after deductible	40% after deductible
Recovery & Rehabilitation		
Home health care *Limited to 120 visits; limit does not apply to Physical, Occupational or Speech Therapy when performed as part of Home Health. Combined in-network and out-of-network.*	20% after deductible	40% after deductible
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office	$40 copay	40% after deductible
Outpatient hospital	$40 copay	40% after deductible
Cardiac rehabilitation		
Office	$40 copay	40% after deductible
Outpatient hospital	$40 copay	40% after deductible
Unlimited visits across outpatient and other professional visits. Combined in-network and out-of-network.		
Skilled nursing care (in a facility) *Limited to 120 combined days for Rehab and Skilled Nursing Facility. Combined in-network and out-of-network.*	20% after deductible	40% after deductible
Durable medical equipment & prosthetics	20% after deductible	40% after deductible

Notes:

- All medical deductibles, copayments and coinsurance apply toward the out of pocket maximum (excluding preventive services that meet the requirements of federal and state law received in network).
- Out-of-network deductibles, copayments, coinsurance and out-of-pocket maximum amounts accumulate toward in-network deductibles, copayments, coinsurance and out-of-pocket maximum amounts.
- Covered in Full (CIF) means you will not have to pay deductible, copayment and/or coinsurance cost shares up to the maximum allowable amount.
- Covered dependents are covered through the end of the month in which the child attains age 26. At the Subscriber's request, eligibility will be continued past this Dependent age limit for an unmarried Dependent child until the end of the month in which the unmarried Dependent child reaches age 28.
- Primary Care Physician (PCP) is a professional provider who is a practitioner who specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other professional provider as allowed by the plan.
- Specialty Provider (SCP) is a professional provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
- Covered physician office based consultations are subject to the applicable office visit copayment.
- Covered specialty drugs obtained through home delivery are limited to a 30 day supply.
- Benefit period refers to both calendar year and plan year.
- If your plan includes a hospital stay copay and you are readmitted within 72 hours of a prior admission for the same diagnosis, your hospital stay copay for your readmission is waived.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- If your plan includes out-of-network benefit and you use a non-participating provider, you are responsible for any difference between the covered expense and the actual non-participating providers charge.
- Human Organ and Tissue Transplants require precertification.
- For additional information on this plan, please visit: www.anthem.com/ca to obtain a "Summary of Benefit Coverage".
- Infertility, including IVF, GIFT, ZIFT, advanced reproductive technologies, artificial insemination, fertility injections/drugs is covered up to $20,000 per lifetime, subject to plan deductibles and coinsurance
- Bariatric surgery is covered up to 1 procedure per lifetime, subject to plan deductibles and coinsurance.
- Transgender surgery, including associated treatment and counseling, are covered subject to plan deductibles and coinsurance.
- Diagnosis and treatment of autism spectrum disorders, including applied behavioral analysis, are covered subject to plan deductibles and coinsurance.