Your summary of benefits

Anthem BlueCross

Your Plan: Anthem Preferred DirectAccess gyfa

Your Network: Select 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.*	Member: $1,500 For Family: $3,000	Member: $3,000 For Family: $6,000
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. If Pediatric Vision and/or Dental services are covered under this plan, these services count towards your out of pocket limit.* *For prescription drug, all cost shares count towards your plan's annual out-of-pocket limit.*	Member: $3,500 For Family: $7,000	Member: $7,000 For Family: $14,000
Doctor Home and Office Services		
Preventive care *In-network preventive care is not subject to deductible, if your plan has a deductible.*	Covered in full	50% coinsurance
Primary care visit to treat an injury or illness	$20 copay	50% coinsurance
Specialist care visit	$40 copay	50% coinsurance
Prenatal and post-natal visit *If you obtain services other than prenatal office visits, please see that setting for your costs.*	No cost share for preventive prenatal	50% coinsurance
Other practitioner visits:		
Retail health clinic	$10 copay	50% coinsurance
Chiropractor services *Limited to 20 visits per year across outpatient and other professional visits.*	$20 copay	50% coinsurance / Anthem maximum payment limited to $25 per visit
Acupuncture	$20 copay	50% coinsurance
Other services in an office:		
Allergy testing	20% coinsurance	50% coinsurance
Chemo/radiation therapy	20% coinsurance	50% coinsurance
Hemodialysis	20% coinsurance	50% coinsurance
Prescription drugs *For the drug itself dispensed in office thru infusion/injection.*	20% coinsurance	50% coinsurance

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Diagnostic Services		
Lab:		
Office	20% coinsurance	50% coinsurance
Outpatient hospital	20% coinsurance	50% coinsurance / Anthem maximum payment limited to $380 per admission
X-ray:		
Office	20% coinsurance	50% coinsurance
Outpatient hospital	20% coinsurance	50% coinsurance / Anthem maximum payment limited to $380 per admission
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office	20% coinsurance	50% coinsurance / Anthem maximum payment limited to $800 per test
Outpatient hospital	20% coinsurance	50% coinsurance / Anthem maximum payment limited to $380 per admission
Emergency and Urgent Care		
Emergency room facility services	$200 copay + 20% coinsurance	Same as in-network
Emergency room doctor and other services	20% coinsurance	Same as in-network
Ambulance (air and ground)	20% coinsurance	Same as in-network
Urgent care (office setting)	$40 copay	50% coinsurance

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Outpatient Mental/Behavioral Health and Substance Abuse **Doctor office visit**	$20 copay	50% coinsurance
Facility visit: Facility fees	20% coinsurance	50% coinsurance / Anthem maximum payment limited to $380 per admission
Outpatient Surgery **Facility fee:** Hospital Freestanding surgical center	20% coinsurance 20% coinsurance	50% coinsurance / Anthem maximum payment limited to $380 per admission 50% coinsurance / Anthem maximum payment limited to $380 per admission
Doctor and other services	20% coinsurance	50% coinsurance
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse) **Facility fee (for example, room & board)**	20% coinsurance	50% coinsurance / Anthem maximum payment limited to $650 per day
Doctor and other services	20% coinsurance	50% coinsurance

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Recovery & Rehabilitation **Home health care** *Limited to 100 4-hour visits per year; limit does not apply to Physical, Occupational or Speech Therapy when performed as part of Home Health.*	$20 copay	50% coinsurance / Anthem maximum payment limited to $75 per visit
Rehabilitation services (for example, physical/speech/occupational therapy): Office	$20 copay	50% coinsurance / Anthem maximum payment limited to $25 per visit
Cardiac rehabilitation Office	$40 copay	50% coinsurance
Skilled nursing care (in a facility) *Limited to 100 days per year.*	20% coinsurance	50% coinsurance / Anthem maximim payment limited to $150 per day
Durable medical equipment & prosthetics	20% coinsurance	50% coinsurance

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Covered Prescription Drug Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
Retail Prescription Drug Coverage ***This plan uses a National Drug List. Drugs not on the list are not covered.*** *This plan includes Home Delivery (Mail Order). Home Delivery copays are 2.5 times retail copays for 90 day supply.*		
Drug tier 1	$15 copay	50% coinsurance
Drug tier 2	$35 copay	50% coinsurance
Drug tier 3	$70 copay	50% coinsurance
Drug tier 4	25% coinsurance	50% coinsurance
Drug tier 4 per-prescription maximum cost share (in-network only)	$250	

Covered Vision Benefits	Cost if you use an In-network Provider
This is a brief outline of your in-network coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, and out-of-network coverage (If applicable), see the combined Evidence of Coverage/Disclosure Form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. *In-network Pediatric Vision benefit cost shares accumulate to the Medical plan out-of-pocket limit and are not subject to the Medical plan deductible, if your plan includes a deductible.*	
Children's Vision Essential Health Benefits	
Vision exam (once every calendar year)	Covered in full
Frames (once every calendar year)	Covered in full
Lenses (once every calendar year)	Covered in full
Elective contact lenses (once every calendar year)	Covered in full

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Notes:

- All medical services subject to a coinsurance are also subject to the annual medical deductible with exception of facility emergency room charge.
- This plan includes an aggregate embedded accumulation for the family deductible and out-of-pocket maximum. This means that the family amounts can be met by any combination of amounts from any family member, however deductible can be met for one member of the family as soon as that one member satisfies the individual deductible or out of pocket amounts.
- For plans with an office visit copay, the copay applies to the actual office visit and additional cost shares may apply for any other service performed in the office (i.e., X-ray, lab, surgery), after any applicable deductible.
- 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 benefits, all services with calendar/plan year limits are combined both in and out of network.
- The dollar copay applies only to the visit itself. An additional copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible"
- If you elect a medical plan that does not include qualified Pediatric/Children's Dental coverage you will be enrolled in a separate Children's Dental plan, unless notification is received that you have enrolled in coverage elsewhere.
- 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.
- For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to ca.sgplans.anthem.com/ca/le
- For additional information on this plan, please visit sbc.anthem.com to obtain a "Summary of Benefit Coverage".