Your summary of benefits

Anthem BlueCross

Anthem Blue Cross of California

Your Plan: Anthem Bronze Select PPO 4800/40%/6550 w/HSA

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 Certificate of Insurance or Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$4,800 person / $9,600 family	$9,600 person / $19,200 family
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. See notes section for additional information regarding your out of pocket maximum.*	$6,550 person / $13,100 family	$13,100 person / $26,200 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	50% coinsurance after deductible is met
Doctor Home and Office Services		
Primary care visit to treat an injury or illness	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Specialist care visit	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Prenatal and Post-natal Care *In-Network preventative prenatal services are covered at 100%*	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Other practitioner visits: Retail health clinic	40% coinsurance after deductible is	50% coinsurance after deductible is

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
	met	met
On-line Visit	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Chiropractor *Coverage for In-Network Providers is limited to 20 visits per benefit period.*	50% coinsurance deductible does not apply	Not covered
Acupuncture	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Other services in an office:		
Allergy testing	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Chemo/radiation therapy	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Hemodialysis	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Prescription drugs *For the drugs itself dispensed in the office thru infusion/injection*	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Diagnostic Services		
Lab:		
Office	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Lab	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital *Coverage for Non-Network Providers is limited to $380 maximum benefit per admission.*	40% coinsurance after deductible is met	50% coinsurance after deductible is met

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X-ray:		
Office	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center *Coverage for Non-Network Providers is limited to $380 maximum benefit per admission.*	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital *Coverage for Non-Network Providers is limited to $380 maximum benefit per admission.*	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office *Coverage for Non-Network Providers is limited to $800 maximum benefit per procedure.*	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center *Coverage for Non-Network Providers is limited to $380 maximum benefit per admission.*	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital *Coverage for Non-Network Providers is limited to $380 maximum benefit per admission.*	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency and Urgent Care		
Emergency room facility services *Cost share except deductible waived if admitted.*	40% coinsurance after deductible is met	40% coinsurance after deductible is met
Emergency room doctor and other services *Cost share except deductible waived if admitted.*	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Ambulance (air and ground)	40% coinsurance after deductible is met	40% coinsurance after deductible is met
Urgent Care (office setting)	40% coinsurance after deductible is	50% coinsurance after deductible is

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
	met	met
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Facility visit:		
Facility fees	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Surgery		
Facility fees:		
Hospital *Coverage for Non-Network Providers is limited to $380 maximum benefit per admission.*	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center *Coverage for Non-Network Providers is limited to $380 maximum benefit per admission.*	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and other services	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)		
Facility fees (for example, room & board) *Coverage for Non-Network Providers is limited to $650 maximum benefit per day. Coverage for Inpatient rehabilitation and skilled nursing services combined In-Network Provider and Non-Network Provider combined is limited to 100 days per benefit period.*	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and other services	40% coinsurance after deductible is	50% coinsurance after deductible is

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
	met	met
Recovery & Rehabilitation		
Home health care *Coverage for In-Network Provider and Non-Network Provider combined is limited to 100 visits per benefit period. Coverage for Non-Network Providers is limited to $75 maximum benefit per visit.*	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient hospital *Coverage for Non-Network Providers is limited to $380 maximum benefit per admission.*	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Habilitation services (for example, physical/speech/occupational therapy):		
Office	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient hospital *Coverage for Non-Network Providers is limited to $380 maximum benefit per admission.*	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation		
Office	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient hospital *Coverage for Non-Network Providers is limited to $380 maximum benefit per admission.*	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled nursing care (in a facility) *Coverage for Non-Network Providers is limited to $150 maximum benefit per day. Coverage for Inpatient rehabilitation and skilled nursing services combined In-Network Provider and Non-Network Provider combined is limited to 100 days per*	40% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
benefit period.		
Hospice	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices	40% coinsurance after deductible is met	50% coinsurance after deductible is met

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Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Combined with medical deductible	Not Applicable
Pharmacy Out of Pocket	Combined with medical out of pocket	Combined with medical out of pocket
Prescription Drug Coverage *Anthem Select Drug List*		
Tier 1 - Typically Generic *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).*	40% coinsurance up to $500 after deductible is met (retail and home delivery)	Not covered
Tier 2 - Typically Preferred Brand & Non-Preferred Generics *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).*	40% coinsurance up to $500 after deductible is met (retail and home delivery)	Not covered
Tier 3 - Typically Non-Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).*	40% coinsurance up to $500 after deductible is met (retail and home delivery)	Not covered
Tier 4 - Typically Specialty (brand and generic) *Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program).*	40% coinsurance up to $500 after deductible is met (retail and home delivery)	Not covered

Your summary of benefits

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, 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. *Only children's vision services count towards your out of pocket limit.*		
Children's Vision Essential Health Benefits		
Child Vision Deductible	Not Applicable	Not Applicable
Vision exam *Coverage for In-Network Provider and Non-Network Provider combined is limited to 1 exam per benefit period.*	No charge	No charge
Frames *Coverage for In-Network Provider and Non-Network Provider combined is limited to 1 unit per benefit period.*	No charge	No charge
Lenses *Coverage for In-Network Provider and Non-Network Provider combined is limited to 1 unit per benefit period.*	No charge	No charge
Elective contact lenses *Coverage for In-Network Provider and Non-Network Provider combined is limited to 1 unit per benefit period.*	No charge	No charge
Non-Elective Contact Lenses *Coverage for In-Network Provider and Non-Network Provider combined is limited to 1 unit per benefit period.*	No charge	No charge
Adult Vision		
Adult Vision Deductible	Not Applicable	Not Applicable
Vision exam *Coverage for In-Network Provider and Non-Network Provider combined is limited to 1 exam per benefit period. Coverage for Non-Network Providers is limited to $30 maximum benefit per visit.*	$20 copay per visit	No charge
Frames	Not covered	Not covered
Lenses	Not covered	Not covered

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Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Elective contact lenses	Not covered	Not covered
Non-Elective Contact Lenses	Not covered	Not covered

Your summary of benefits

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your dental coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, 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. *Only children's dental services count towards your out of pocket limit.*		
Children's Dental Essential Health Benefits **Diagnostic and preventive** *Coverage for In-Network Provider and Non-Network Provider combined is limited to 1 visit per 6 months.*	No charge	No charge
Basic services	20% coinsurance	20% coinsurance
Major services	50% coinsurance	50% coinsurance
Medical Necessary Orthodontia services	50% coinsurance	50% coinsurance
Cosmetic Orthodontia services	Not covered	Not covered
Deductible	Not Applicable	Not Applicable
Adult Dental		
Diagnostic and preventive	Not covered	Not covered
Basic services	Not covered	Not covered
Major services	Not covered	Not covered
Deductible	Not Applicable	Not Applicable
Annual maximum	Not Applicable	Not Applicable

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Notes:

- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.
- Your coinsurance, copays and deductible count toward your out of pocket amount
- Coverage for Non-emergency ambulance service for Non-Network Providers is limited to $50,000 maximum benefit per occurrence.
- For additional information on this plan, please visit sbc.anthem.com to obtain a "Summary of Benefit Coverage".
- For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to ca.sgplans.anthem.com/ca/le
- All medical services subject to a coinsurance are also subject to the annual medical 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 out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- If your plan includes out of network benefits and you use a non-participating provider, you are responsible for any difference between the covered expense and the actual non-participating providers charge.
- Vision services are not subject to the annual deductible.
- Certain services are subject to the utilization review program or precertification. Before scheduling services, the member must make sure utilization or precertification review is obtained. If utilization or precertification review is not obtained, benefits may be reduced or not paid according to the plan.

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