Your summary of benefits

Your Plan: Anthem Silver PPO 1750/35%/6850

Your Network: Prudent Buyer 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 *This is an embedded deductible plan. See notes section at the end of the document to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Retail Prescription Drug Coverage section.*	Member: $1,750 For Family: $3,500	Member: $3,500 For Family: $7,000
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. See notes section at the end of the document for additional information regarding your out of pocket maximum.* *For prescription drug, all cost shares count towards your plan's annual out-of-pocket limit.*	Member: $6,850 For Family: $13,700	Member: $13,700 For Family: $27,400
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 after deductible
Primary care visit to treat an injury or illness	$25 copay	50% coinsurance after deductible
Specialist care visit	$45 copay	50% coinsurance after deductible
Prenatal care	Covered in full	50% coinsurance after deductible
Postpartum care	$25 copay	50% coinsurance 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
Doctor Home and Office Services (*continued)*		
Other practitioner visits:		
Retail health clinic	$15 copay	50% coinsurance after deductible
On-line visit	$25 copay	50% coinsurance after deductible
Chiropractor services *Limited to 20 visits per calendar year. Visit limit is combined both across outpatient and other professional visits, and in and out of network.*	$25 copay	50% coinsurance after deductible/ Anthem maximum payment limited to $25 per visit.
Acupuncture	$25 copay	50% coinsurance after deductible
Other services in an office:		
Allergy testing	35% coinsurance after deductible	50% coinsurance after deductible
Chemo/radiation therapy	35% coinsurance after deductible	50% coinsurance after deductible
Hemodialysis	35% coinsurance after deductible	50% coinsurance after deductible
Prescription drugs *For the drug itself dispensed in office thru infusion/injection.*	35% coinsurance after deductible	50% coinsurance 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	35% coinsurance after deductible	50% coinsurance after deductible
Outpatient hospital	35% coinsurance after deductible	50% coinsurance after deductible/ Anthem maximum payment limited to $380 per admission.
X-ray:		
Office	35% coinsurance after deductible	50% coinsurance after deductible
Outpatient hospital	35% coinsurance after deductible	50% coinsurance after deductible/ Anthem maximum payment limited to $380 per admission.
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office	35% coinsurance after deductible	50% coinsurance after deductible/ Anthem maximum payment limited to $800 per procedure.
Outpatient hospital	35% coinsurance after deductible	50% coinsurance after deductible/ Anthem maximum payment limited to $380 per admission.

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Covered Medical Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
Emergency and Urgent Care		
Urgent care (office setting)	$100 copay	50% coinsurance after deductible
Emergency room facility services	$300 copay and then 35% coinsurance	Same as In Network
Emergency room doctor and other services	35% coinsurance after deductible	Same as In Network
Ambulance (air and ground)	35% coinsurance after deductible	Same as In Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit	$25 copay	50% coinsurance after deductible
Facility visit:		
Facility fees	35% coinsurance after deductible	50% coinsurance after deductible
Doctor services	35% coinsurance after deductible	50% coinsurance after deductible
Outpatient Surgery		
Facility fee:		
Hospital	35% coinsurance after deductible	50% coinsurance after deductible/ Anthem maximum payment limited to $380 per admission.
Doctor services:		
Hospital	35% coinsurance after deductible	50% coinsurance after deductible

Covered Medical Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse) **Facility fee (for example, room & board)**	35% coinsurance after deductible	50% coinsurance after deductible/ Anthem maximum payment limited to $650 per day.
Doctor and other services	35% coinsurance after deductible	50% coinsurance after deductible
Recovery & Rehabilitation **Home health care** *Limited to 100 4-hour visits per calendar year,combined in and out of network. Visit limit includes Private Duty Nursing when performed as part of Home Health. Visit limit does not apply to Physical, Occupational or Speech Therapy when performed as part of Home Health.*	$25 copay	50% coinsurance after deductible/ Anthem maximum payment limited to $75 per visit.
Rehabilitation services **(for example, physical/speech/occupational therapy):** Office	$25 copay	50% coinsurance after deductible
Outpatient hospital	35% coinsurance after deductible	50% coinsurance after deductible/ Anthem maximum payment limited to $380 per admission.
Skilled nursing care (in a facility) *Limited to 100 days per benefit period, combined in and out of network.*	35% coinsurance after deductible	50% coinsurance after deductible/ Anthem maximum payment limited to $150 per day.
Durable medical equipment & prosthetics	35% coinsurance after deductible	50% coinsurance after deductible

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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 Select Drug List. Drugs not on the list are not covered.*** ***This plan includes Home Delivery (Mail Order), Home Delivery copays are 2.5 [Tier 1], 3.0 [Tier 2], 3.0 [Tier 3] times retail copays and select drugs are available for up to a 90 day supply.***		
Drug tier 1 - Typically Generic	$15 copay	50% coinsurance
Drug tier 2 - Typically Preferred / Formulary Brand	$40 copay	50% coinsurance
Drug tier 3 - Typically Non-preferred/Non-formulary and Specialty Drugs	$80 copay	50% coinsurance
Drug tier 4 - Typically Specialty Drugs	25% coinsurance	50% coinsurance
Drug tier 4 per-prescription maximum cost share	$250	Not applicable

Your summary of benefits

Covered Vision Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-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.*	*Eye exams are covered once per calendar year. For children through age 18, there is a selection of frames and contact lenses that are covered under this plan. Eyeglass lenses and Frames are covered once per calendar year. Contact Lens benefit available only if eyeglass lens benefit is not used. Review the formal contract of coverage or contact your vision provider for more information.*	*For covered services with a reimbursement amount, you will have no cost share up to that amount. All costs beyond the reimbursement amount are subject to balance billing.*
Children's Vision Essential Health Benefits **Vision exam**	$0 copay	$0 Copayment plus any charges in excess of the Maximum Allowed Amount
Frames	$0 copay	$0 Copayment plus any charges in excess of the Maximum Allowed Amount
Lenses		
Single	$0 copay	$0 Copayment plus any charges in excess of the Maximum Allowed Amount
Bifocal	$0 copay	$0 Copayment plus any charges in excess of the Maximum Allowed Amount
Trifocal	$0 copay	$0 Copayment plus any charges in excess of the Maximum Allowed Amount

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Elective Contact Lenses	$0 copay	$0 Copayment plus any charges in excess of the Maximum Allowed Amount
Non-Elective Contact Lenses	$0 copay	$0 Copayment plus any charges in excess of the Maximum Allowed Amount

Covered Vision Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
Adult Vision Benefits **Vision exam**	$20 copay	$30 reimbursement
Frames	Not covered	Not covered
Lenses		
Single	Not covered	Not covered
Bifocal	Not covered	Not covered
Trifocal	Not covered	Not covered
Elective Contact Lenses	Not covered	Not covered
Non-Elective Contact Lenses	Not covered	Not covered

Covered Dental Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-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. *Children's dental services count towards your out of pocket limit.*		
Children's Dental Essential Health Benefits **Diagnostic and preventive**	0% coinsurance	0% coinsurance
Basic services	50% coinsurance after deductible	50% coinsurance after deductible
Major services	50% coinsurance after deductible	50% coinsurance after deductible
Medically Necessary Orthodontia services	50% coinsurance after deductible	50% coinsurance after deductible
Cosmetic Orthodontia services	Not covered	Not covered
Deductible (Applies to all services except diagnostic & preventive)	Combined with Medical	Combined with Medical
Out-of-Pocket Limit	Combined with Medical	Combined with Medical
Adult Dental Benefits **Diagnostic and preventive**	Not covered	Not covered
Basic services	Not covered	Not covered
Major services	Not covered	Not covered
Deductible	Not covered	Not covered
Out-of-Pocket Limit	Not covered	Not covered

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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 copays, coinsurance and deductible count toward your out of pocket amount, except for copays for Adult Vision exams.

- Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.

- 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 in addition to any applicable copayments, coinsurance and/or deductible. This amount does not apply to the out-of-network out-of-pocket limit.

- 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.

- 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.

- Non-emergency, out-of-network air ambulance services are limited to Anthem maximum payment of $50,000 per trip.

- 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”.