Your summary of benefits

Anthem

Anthem® Blue Cross Life and Health Insurance Company

Your Plan: San Joaquin Valley Insurance Authority (JPA): County of Fresno - Custom EPO 0 (YOSEMITE)

Your Network: EPO

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge
Mental Health & Substance Use Disorder Services	No charge
Specialist care	$15 copay per visit

Covered Medical Benefits	Cost if you use an In-Network Provider
Overall Deductible	$0 person
Overall Out-of-Pocket Limit	$1,000 person / $2,000 family
To get benefits under this Plan, you must use In-Network Providers. **Services from Out-of-Network Providers are not covered**, except for Emergency Care, Authorized Services, or when required by law. Please be sure to contact us if you are not sure if we have approved an Authorized Service. The family out-of-pocket limit is embedded, meaning each covered person is capped at his or her per person out-of-pocket limit; in addition, cost shares for all covered family members apply to the family out-of-pocket limit, yet no one member will pay more than the per person out-of-pocket limit. All medical deductibles, copayments and coinsurance apply to the out-of-pocket limit.	
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*	
Primary Care (PCP) and Mental Health and Substance Use Disorder Services *virtual and office*	$15 copay per visit
Specialist Care *virtual and office*	$15 copay per visit
Other Practitioner Visits	
Maternity Doctor services (prenatal/postnatal care and delivery)	No charge
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$15 copay per visit
Manipulation Therapy *Coverage is limited to 40 visits per benefit period.*	$10 copay per visit

Covered Medical Benefits	Cost if you use an In-Network Provider
Acupuncture	$15 copay per visit
Other Services in an Office **Allergy Testing** **Prescription Drugs** *Dispensed in the office* *Maximum of $250 member cost share per drug.* **Surgery**	 No charge No charge No charge
Preventive care / screenings / immunizations	No charge
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge
Diagnostic Services **Lab** Office Freestanding Lab Outpatient Hospital	 No charge No charge No charge
X-Ray Office Freestanding Radiology Center Outpatient Hospital	 No charge No charge No charge
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans* Office Freestanding Radiology Center Outpatient Hospital	 No charge No charge No charge
Emergency and Urgent Care **Urgent Care** *includes doctor services. Additional charges may apply depending on the care provided.*	 $15 copay per visit

Covered Medical Benefits	Cost if you use an In-Network Provider
Emergency Room Facility Services *Your copay will be waived if admitted.*	**In-Network and Out-of-Network Providers:** $100 copay per visit
Emergency Room Doctor and Other Services	**In-Network and Out-of-Network Providers:** No charge
Ambulance *Authorized Out-of-Network non-emergency ambulance services are limited to an Anthem maximum payment of $50,000 per trip.*	**In-Network and Out-of-Network Providers:** No charge
Outpatient Mental Health and Substance Use Disorder Services at a Facility	
Facility Fees	No charge
Doctor Services	No charge
Outpatient Surgery	
Facility Fees	
Hospital	No charge
Ambulatory Surgical Center	No charge
Physician and other services *including surgeon fees*	
Hospital	No charge
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)	
Facility Fees	No charge
Physician and other services *including surgeon fees*	No charge
Home Health Care *Coverage is limited to 100 visits per benefit period.*	$15 copay per visit
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for physical, occupational and speech therapies is limited to 60 days combined per benefit period.*	
Office	$15 copay per visit
Outpatient Hospital	No charge
Pulmonary rehabilitation	

Covered Medical Benefits	Cost if you use an In-Network Provider
Office Outpatient Hospital	$15 copay per visit No charge
Cardiac rehabilitation Office Outpatient Hospital	 $15 copay per visit No charge
Dialysis/Hemodialysis *office and outpatient hospital*	No charge
Chemo/Radiation Therapy *office and outpatient hospital*	No charge
Skilled Nursing Care (facility) *Coverage is limited to 100 days per benefit period.*	No charge
Inpatient Hospice	No charge
Durable Medical Equipment	No charge
Prosthetic Devices	No charge

Notes:

- If you have an office visit with your Primary Care Physician, Specialist or Urgent Care at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
- Coverage includes standard fertility preservation services as a basic healthcare service including but are not limited to, injections, cryopreservation and storage for both male and female members when a medically necessary treatment may cause iatrogenic infertility. Member cost share for fertility preservation services is based on provider type and service rendered.

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

Questions: (855) 333-5730 or visit us at www.anthem.com/ca