

Your summary of benefits



Anthem® Blue Cross Life and Health Insurance Company

Your Plan: San Joaquin Valley Insurance Authority (JPA): County of Fresno - PPO HDHP 1650

Your Network: Prudent Buyer PPO

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge after deductible is met
Mental Health & Substance Use Disorder Services	No charge after deductible is met
Specialist care	No charge after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible <i>Subscriber Only Coverage</i>	\$1,650 individual	\$1,650 individual
<i>Subscriber and Family Coverage</i>	\$3,300 member / \$3,300 family	\$3,300 member / \$3,300 family
Overall Out-of-Pocket Limit <i>Subscriber Only Coverage</i>	\$3,300 individual	\$10,000 individual
<i>Subscriber and Family Coverage</i>	\$3,300 member / \$6,000 family	\$10,000 member / \$15,000 family

The individual deductible and individual out-of-pocket limit apply to an individual enrolled under subscriber only coverage.

The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the member deductible and member out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the member deductible or member out-of-pocket limit.

All medical deductibles, copayments and coinsurance apply to the out-of-pocket limit.

In-Network and Out-of-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.

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 <i>virtual and office</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Specialist Care <i>virtual and office</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<u>Other Practitioner Visits</u>		
Maternity Doctor services (prenatal/postnatal care and delivery)	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Manipulation Therapy <i>Coverage is limited to 24 visits per benefit period.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Acupuncture <i>Coverage is limited to 12 visits per benefit period.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<u>Other Services in an Office</u>		
Allergy Testing	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prescription Drugs <i>Dispensed in the office</i> <i>Maximum of \$250 member cost share per drug.</i>	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Surgery	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	40% coinsurance after deductible is met
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	40% coinsurance after deductible is met
<u>Diagnostic Services</u>		
Lab		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Lab	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
X-Ray		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i> Office Freestanding Radiology Center Outpatient Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met
<u>Emergency and Urgent Care</u> Urgent Care <i>includes doctor services. Additional charges may apply depending on the care provided.</i> Emergency Room Facility Services Emergency Room Doctor and Other Services Ambulance	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met Covered as In-Network Covered as In-Network Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility Facility Fees Doctor Services	20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met
<u>Outpatient Surgery</u> Facility Fees Hospital Ambulatory Surgical Center Physician and other services <i>including surgeon fees</i> Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met
<u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u> Facility Fees	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Physician and other services <i>including surgeon fees</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Home Health Care <i>Coverage is limited to 100 visits per benefit period.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies.</i>		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Pulmonary rehabilitation <i>office and outpatient hospital</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Cardiac rehabilitation <i>office and outpatient hospital</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Dialysis/Hemodialysis <i>office and outpatient hospital</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Chemo/Radiation Therapy <i>office and outpatient hospital</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Skilled Nursing Care (facility) <i>Coverage is limited to 100 days per benefit period.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Inpatient Hospice	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Durable Medical Equipment	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prosthetic Devices	20% coinsurance after deductible is met	40% coinsurance after deductible is met

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.
- Outpatient Facility tests and treatments are limited to \$350 per admission for Out-of-Network Providers. Includes: Diagnostic Services; X-ray; Surgery; Rehabilitation; Habilitation; Cardiac Therapy; Surgery at Ambulatory Surgical Centers.
- 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.

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