

# Your summary of benefits



Anthem® Blue Cross

Your Plan: Anthem PPO HSA 5000/20

Your Network: Prudent Buyer PPO

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
<b>Primary Care, and medical services for urgent/acute care</b>	No charge after deductible is met
<b>Mental Health &amp; Substance Use Disorder Services</b>	No charge after deductible is met
<b>Specialist care</b>	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b>	\$5,000 person / \$10,000 family	\$15,000 person / \$30,000 family
<b>Overall Out-of-Pocket Limit</b>	\$7,500 person / \$15,000 family	\$22,500 person / \$45,000 family

The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person 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 per person deductible or per person out-of-pocket limit.

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

In-Network and Non-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).*

<b>Primary Care (PCP) and Mental Health and Substance Use Disorder Services</b> <i>virtual and office</i>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Specialist Care</b> <i>virtual and office</i>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b><u>Other Practitioner Visits</u></b>		
<b>Routine Maternity Care</b> (Prenatal and Postnatal)	20% 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
<b>Retail Health Clinic</b> for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Manipulation Therapy</b> Coverage is limited to 30 visits per benefit period.	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Acupuncture</b> Coverage is limited to 20 visits per benefit period.	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<u><b>Other Services in an Office</b></u> <b>Allergy Testing</b>  <b>Prescription Drugs</b> Dispensed in the office Maximum of \$250 member cost share per drug. <b>Surgery</b>	20% coinsurance after deductible is met  30% coinsurance after deductible is met  20% coinsurance after deductible is met	50% coinsurance after deductible is met  50% coinsurance after deductible is met  50% coinsurance after deductible is met
<b>Preventive care / screenings / immunizations</b>	No charge	50% coinsurance after deductible is met
<b>Preventive Care for Chronic Conditions</b> per IRS guidelines	No charge	50% coinsurance after deductible is met
<u><b>Diagnostic Services</b></u> <b>Lab</b> Office Freestanding Lab Outpatient Hospital	20% coinsurance after deductible is met  20% coinsurance after deductible is met  20% coinsurance after deductible is met	50% coinsurance after deductible is met  50% coinsurance after deductible is met  50% coinsurance after deductible is met
<b>X-Ray</b> Office Freestanding Radiology Center Outpatient Hospital	20% coinsurance after deductible is met  20% coinsurance after deductible is met  20% coinsurance after deductible is met	50% coinsurance after deductible is met  50% coinsurance after deductible is met  50% coinsurance after deductible is met
<b>Advanced Diagnostic Imaging</b> for example: MRI, PET and CAT scans  Office	20% 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
<p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><b><u>Emergency and Urgent Care</u></b></p> <p><b>Urgent Care</b> <i>includes doctor services. Additional charges may apply depending on the care provided.</i></p> <p><b>Emergency Room Facility Services</b></p> <p><b>Emergency Room Doctor and Other Services</b></p> <p><b>Ambulance</b> <i>Authorized Non-Network non-emergency ambulance services are limited to an Anthem maximum payment of \$50,000 per trip.</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p><b><u>Outpatient Mental Health and Substance Use Disorder Services at a Facility</u></b></p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><b><u>Outpatient Surgery</u></b></p> <p><b>Facility Fees</b></p> <p>Hospital</p> <p>Ambulatory Surgical Center</p> <p><b>Physician and other services including surgeon fees</b></p> <p>Hospital</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><b><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u></b> <i>Anthem's maximum payment is up to \$1,000 per day for non-emergency Inpatient admissions to Non-Network Providers.</i></p> <p><b>Facility Fees</b></p> <p><b>Physician and other services including surgeon fees</b></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Home Health Care</b> <i>Coverage is limited to 100 visits per benefit period.</i>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Rehabilitation and Habilitation services</b> <i>including physical, occupational and speech therapies.</i>  Office  Outpatient Hospital	20% coinsurance after deductible is met  20% coinsurance after deductible is met	50% coinsurance after deductible is met  50% coinsurance after deductible is met
<b>Pulmonary rehabilitation</b> <i>office and outpatient hospital</i>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Cardiac rehabilitation</b> <i>office and outpatient hospital</i>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Dialysis/Hemodialysis</b> <i>office and outpatient hospital</i>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Chemo/Radiation Therapy</b> <i>office and outpatient hospital</i>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Skilled Nursing Care (facility)</b> <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.</i>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Inpatient Hospice</b>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Durable Medical Equipment</b>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Prosthetic Devices</b>	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<b>Pharmacy Deductible</b>	Combined with In-Network medical deductible	Combined with Non-Network medical deductible
<b>Pharmacy Out-of-Pocket Limit</b>	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit

Covered Prescription Drug Benefits	Cost if you use an In- Network Pharmacy	Cost if you use a Non-Network Pharmacy
<p><b>Prescription Drug Coverage</b>  <b>Network: <i>Base Network</i></b>  <b>Drug List: <i>Essential</i></b> Drugs not included on the <i>Essential</i> drug list will not be covered.</p>		
<p><b>Day Supply Limits:</b>  <b>Retail Pharmacy</b> 30 day supply (cost shares noted below)  <b>Retail 90 Pharmacy</b> 90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).  <b>Home Delivery Pharmacy</b> 90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail. You will need to call us on the number on your ID card to sign up when you first use the service.  <b>Specialty Pharmacy</b> 30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.</p>		
<p><b>Preventive Drugs</b> No deductible, copayment or coinsurance applies to prescription drugs on the <i>PreventiveRX Plus</i> drug list when you use an <i>In-Network Pharmacy</i>.</p>		
<p><b>Tier 1a - Typically Lower Cost Generic</b></p>	<p>\$5 copay per prescription after deductible is met (retail) and \$10 copay per prescription after deductible is met (home delivery)</p>	<p>50% coinsurance up to \$250 per prescription after deductible is met (retail) and Not covered (home delivery)</p>
<p><b>Tier 1b - Typically Generic</b></p>	<p>\$15 copay per prescription after deductible is met (retail) and \$30 copay per prescription after deductible is met (home delivery)</p>	<p>50% coinsurance up to \$250 per prescription after deductible is met (retail) and Not covered (home delivery)</p>
<p><b>Tier 2 – Typically Preferred Brand</b></p>	<p>\$40 copay per prescription after deductible is met (retail) and \$100 copay per prescription after deductible is met (home delivery)</p>	<p>50% coinsurance up to \$250 per prescription after deductible is met (retail) and Not covered (home delivery)</p>
<p><b>Tier 3 - Typically Non-Preferred Brand</b></p>	<p>\$60 copay per prescription after deductible is met (retail) and \$150 copay per prescription after deductible is met (home delivery)</p>	<p>50% coinsurance up to \$250 per prescription after deductible is met (retail) and Not covered (home delivery)</p>

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<b>Tier 4 - Typically Specialty (brand and generic)</b>	30% coinsurance up to \$250 per prescription after deductible is met (retail and home delivery)	50% coinsurance up to \$250 per prescription after deductible is met (retail) and Not covered (home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<i>This is a brief outline of your vision coverage. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out-of-pocket limit.</i>		
<b>Children's Vision exam (up to age 19)</b> <i>Limited to 1 exam per benefit period.</i>	No charge	\$0 copayment up to plan's Maximum Allowed Amount
<b>Adult Vision exam (age 19 and older)</b> <i>Limited to 1 exam per benefit period.</i>	No charge	Reimbursed Up to \$42

**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 Non-Network Providers. Includes: Diagnostic Services; X-ray; Surgery; Rehabilitation; Habilitation; Cardiac Therapy; Surgery at Ambulatory Surgical Centers.
- Advanced Diagnostic Imaging is limited to \$800 per service for Non-Network Providers.
- 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.
- The representations of benefits in this document are subject to California Department of Managed Health Care (DMHC) approval and are subject to change.

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

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## Get help in your language

### Language Assistance Services

Curious to know what all this says? We would be too. Here's the English version:

**IMPORTANT:** Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

#### Spanish

**IMPORTANTE:** ¿Puede leer esta carta? De lo contrario, podemos hacer que alguien lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721. (TTY/TDD: 711)

#### Arabic

مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاستعانة بشخص ما ليساعدك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم 1-888-254-2721 (TTY/TDD:711).

#### Armenian

ՈՒՇՏԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող ենք նաև այս նամակը Ձեզ գրավոր տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-888-254-2721 հեռախոսահամարով: (TTY/TDD: 711)

#### Chinese

**重要事項:** 您能看懂這封信函嗎? 如果您看不懂, 我們能夠找人協助您。您有可能可以獲得以您的語言而寫的本信函。如需免費協助, 請立即撥打1-888-254-2721。(TTY/TDD: 711)

#### Farsi

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر نمی‌توانید، می‌توانیم شخصی را به شما معرفی کنیم تا در خواندن این نامه شما را کمک کند. همچنین می‌توانید این نامه را به صورت مکتوب به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، همین حالا با شماره 1-888-254-2721 تماس بگیرید. (TTY/TDD:711)

#### Hindi

**महत्वपूर्ण:** क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम आपको इसे पढ़ने में मदद करने के लिए किसी को उपलब्ध करा सकते हैं। आप यह पत्र अपनी भाषा में लिखवाने में भी सक्षम हो सकते हैं। निःशुल्क मदद के लिए, कृपया 1-888-254-2721 पर तुरंत कॉल करें। (TTY/TDD: 711)

#### Hmong

**TSEEM CEEB:** Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwm tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

#### Japanese

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重要：この書簡を読めますか？もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたものを入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。  
1-888-254-2721 (TTY/TDD: 711)

**Khmer**  
សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ យើងអាចឱ្យមន្ត្រីនិយាយជាភាសាដទៃសម្រាប់អ្នកផងដែរ។ បើអ្នកទទួលបានលិខិតនេះដោយសរសេរជាភាសាដទៃសម្រាប់អ្នកផងដែរ។ សូមហៅទូរស័ព្ទភ្លាមៗទៅលេខ 1-888-254-2721។ (TTY/TDD: 711)

**Korean**  
중요: 이 서신을 읽으실 수 있으십니까? 읽으실 수 없을 경우 도움을 드릴 사람이 있습니다. 귀하가 사용하는 언어로 쓰여진 서신을 받으실 수도 있습니다. 무료 도움을 받으시려면 즉시 1-888-254-2721로 전화하십시오. (TTY/TDD: 711)

**Punjabi**  
ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹ ਕੇ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸੀਂ ਸਾਇੰਟ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵੱਧੀ ਪੜ੍ਹਾਏ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਫੋਨ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ।  
(TTY/TDD: 711)

**Russian**  
ВАЖНО. Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721.  
(TTY/TDD: 711)

**Tagalog**  
MAHALAGA: Nababasa ba ninyo ang liham na ito? Kung hindi, may taong maaaring tumulong sa inyo sa pagbasa nito. Maaari ninyo ring makuha ang liham na ito nang nakasulat sa ginagamit ninyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

**Thai**  
หมายเหตุสำคัญ: ท่านสามารถอ่านจดหมายฉบับนี้หรือไม่ หากท่านไม่สามารถอ่านจดหมายฉบับนี้ เราสามารถจัดหาเจ้าหน้าที่มาอ่านให้ท่านฟังได้ ท่านยังอาจให้เจ้าหน้าที่ช่วยเขียนจดหมายในภาษาของท่านอีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อที่หมายเลข 1-888-254-2721 (TTY/TDD: 711)

**Vietnamese**  
QUAN TRỌNG: Quý vị có thể đọc thư này hay không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc thư này. Quý vị cũng có thể nhận thư này bằng ngôn ngữ của quý vị. Để được giúp đỡ miễn phí, vui lòng gọi ngay số 1-888-254-2721. (TTY/TDD: 711)

**It's important we treat you fairly**

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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