# Your summary of benefits

Anthem

Anthem® Blue Cross

Your Plan: Anthem Prudent Buyer PPO HSA 4000/20

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 deductible does not apply |
| **Mental Health & Substance Use Disorder Services** | No charge deductible does not apply |
| **Specialist care** | 20% 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 |
|---|---|---|
| **Overall Deductible** | $4,000 person / $8,000 family | $12,000 person / $24,000 family |
| **Overall Out-of-Pocket Limit** | $7,000 person / $14,000 family | $21,000 person / $42,000 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.<br>All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit.<br>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)** *virtual and office* | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Mental Health and Substance Use Disorder Services** *virtual and office* | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Specialist Provider** *virtual and office* | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Other Practitioner Visits** | | |
| **Maternity Doctor services** (prenatal/postpartum care and delivery) | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Retail Health Clinic** *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 |
| **Manipulation Therapy**<br>*Coverage is limited to 30 visits per benefit period.* | 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 an Out-of-Network Provider |
|---|---|---|
| **Acupuncture**<br>*Coverage is limited to 20 visits per benefit period.* | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Other Services in an Office** | | |
| **Allergy Testing** | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Prescription Drugs** *Dispensed in the office*<br>*Maximum of $250 member cost share per drug.* | 30% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Surgery** | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Preventive care / screenings / immunizations** | No charge | 50% coinsurance after deductible is met |
| **Preventive Care for Chronic Conditions** *per IRS guidelines* | No charge | Cost share is based on the setting services are received. |
| **Diagnostic Services Lab** | | |
| Office | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Freestanding Lab | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Outpatient Hospital | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Diagnostic Services X-Ray** | | |
| Office | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Freestanding Radiology Center | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Outpatient Hospital | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Diagnostic Services Advanced Diagnostic Imaging** *for example: MRI, PET and CAT scans* | | |
| Office | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Freestanding Radiology Center | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Outpatient Hospital | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Emergency and Urgent Care** | | |
| **Urgent Care** *includes doctor services. Additional charges may apply depending on the care provided.* | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Emergency Room Facility Services** | 20% coinsurance after deductible is met | Covered as In-Network |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|
| **Emergency Room Doctor and Other Services** | 20% coinsurance after deductible is met | Covered as In-Network |
| **Ambulance** | 20% coinsurance after deductible is met | Covered as In-Network |
| **Outpatient Mental Health and Substance Use Disorder Services at a Facility** | | |
| **Facility Fees** | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Doctor Services** | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Outpatient Surgery** | | |
| **Facility Fees** | | |
| Hospital | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Ambulatory Surgical Center | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Physician and other services** *including surgeon fees* | | |
| Hospital | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)**<br>*Anthem's maximum payment is up to $1,000 per day for non-emergency Inpatient admissions to Out-of-Network Providers.* | | |
| **Facility Fees** | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Physician and other services** *including surgeon fees* | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Home Health Care**<br>*Coverage is limited to 100 visits per benefit period.* | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Therapy Services** | | |
| **Rehabilitation and Habilitation services** *including physical, occupational and speech therapies.* | | |
| Office | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Outpatient Hospital | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Pulmonary rehabilitation** *office and outpatient hospital* | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Cardiac rehabilitation** *office and outpatient hospital* | 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 an Out-of-Network Provider |
|---|---|---|
| **Dialysis/Hemodialysis** *office and outpatient hospital* | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Chemo/Radiation Therapy** *office and outpatient hospital* | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Skilled Nursing Care (facility)**<br>*Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.* | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Inpatient Hospice** | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Additional Services, Equipment and Devices**<br>**Durable Medical Equipment** | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Prosthetic Devices** | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| **Wigs**<br>*Coverage for wigs is limited to 1 item after cancer treatment per benefit period.* | 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 an Out-of-Network Pharmacy |
|---|---|---|
| **Pharmacy Deductible** | Combined with In-Network medical deductible | Combined with Out-of-Network medical deductible |
| **Pharmacy Out-of-Pocket Limit** | Combined with In-Network medical out-of-pocket limit | Combined with Out-of-Network medical out-of-pocket limit |

**Prescription Drug Coverage**
**Network:** ***Base Network***
**Drug List:** ***CA Essential DMHC*** *Drugs not included on the CA Essential DMHC drug list will not be covered.*
***For more information, refer to "CA Essential DMHC Drug List" at*** https://www.anthem.com/ca/pharmacy-information/.

**Day Supply Limits**
**Retail Pharmacy:** *30 day supply (cost shares noted below)*
**Retail 90 Pharmacy:** *90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).*
**Home Delivery Pharmacy:** *90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.*
**Specialty Pharmacy:** *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.*

**Preventive Drugs:** *No deductible, copayment or coinsurance applies to prescription drugs on the PreventiveRX Plus drug list when you use an In-Network Pharmacy.*

| Covered Prescription Drug Benefits | Cost if you use an In-Network Pharmacy | Cost if you use an Out-of-Network Pharmacy |
|---|---|---|
| **Tier 1a - Typically Lower Cost Generic** | $5 copay per prescription after deductible is met (retail) and $10 copay per prescription after deductible is met (home delivery) | 50% coinsurance up to $250 per prescription after deductible is met (retail) and Not covered (home delivery) |
| **Tier 1b - Typically Generic** | $20 copay per prescription after deductible is met (retail) and $40 copay per prescription after deductible is met (home delivery) | 50% coinsurance up to $250 per prescription after deductible is met (retail) and Not covered (home delivery) |
| **Tier 2 - Typically Preferred Brand** | $40 copay per prescription after deductible is met (retail) and $100 copay per prescription after deductible is met (home delivery) | 50% coinsurance up to $250 per prescription after deductible is met (retail) and Not covered (home delivery) |
| **Tier 3 - Typically Non-Preferred Brand** | $60 copay per prescription after deductible is met (retail) and $150 copay per prescription after deductible is met (home delivery) | 50% coinsurance up to $250 per prescription after deductible is met (retail) and Not covered (home delivery) |
| **Tier 4 - Typically Specialty (brand and generic)** | 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 an Out-of-Network Provider |
|---|---|---|
| *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.* | | |
| **Children's Vision exam (up to age 19)**<br>*Limited to 1 exam per benefit period.* | No charge | $0 copayment up to plan's Maximum Allowed Amount |
| **Adult Vision exam (age 19 and older)** | No charge | Reimbursed Up to $42 |

| Covered Vision Benefits | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|
| *Limited to 1 exam per benefit period.* | | |

**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; Allergy Testing.
- Advanced Diagnostic Imaging is limited to $800 per service for Out-of-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.
- Coverage includes the diagnosis and treatment of infertility and fertility services, including a maximum of three completed oocyte retrievals with unlimited embryo transfers in accordance with the guidelines of the American Society of Reproductive Medicine (ASRM). These services are provided on the same basis, at the same cost shares, as any other medical condition.
- 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

Anthem

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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 with translations or interpreter services, in a timely manner, please call the telephone number on the back of your ID card. (TTY/TDD:711)

Separate from our language assistance program, we make documents available in alternative 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? Si no es así, podemos pedirle a alguien que lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda oportuna y gratuita con traducciones o servicios de interpretación, llame al número de teléfono que figura en el dorso de su tarjeta de identificación. (TTY/TDD: 711).

**Arabic**
هام: هل يمكنك قراءة هذه الرسالة؟ إذا لم يكن الأمر كذلك، فيمكننا أن نطلب من شخص ما مساعدتك في قراءتها. قد تتمكن أيضا من الحصول على هذه الرسالة مكتوبة بلغتك. للحصول على مساعدة مجانية في خدمات الترجمة أو الترجمة الفورية، في الوقت المناسب، يرجى الاتصال برقم الهاتف الموجود على ظهر بطاقة الهوية الخاصة بك. (TTY/TDD:711).

**Armenian**
ԿԱՐԵՎՈՐ Է. կարողանո՞ւմ եք կարդալ այս նամակը: Եթե ոչ, կարող ենք օգնել ձեզ կարդալ այն: Դուք կարող եք նաև ստանալ այս նամակը գրավոր՝ ձեր լեզվով: Թարգմանությունների կամ թարգմանչական ծառայությունների անվճար օգնության համար, ժամանակին, խնդրում ենք զանգահարել ձեր ID քարտի հակառակ կողմում նշված հեռախոսահամարով: (TTY/TDD՝ 711):

**Chinese**
重要提示：您能讀懂這封信嗎？如果不能，我們可以請人幫您看。您還可以獲得以您的語言寫的此信件。如需及時獲得免費的翻譯或口譯服務協助，請撥打您 ID 卡背面的電話號碼。(TTY/TDD:711)。

**Farsi**
مهم: می‌توانید این نامه را بخوانید؟ اگر نه، می‌توانیم از کسی بخواهیم که در خواندن آن به شما کمک کند. همچنین ممکن است بتوانید این نامه را به زبان خودتان دریافت کنید. برای دریافت کمک رایگان و به‌موقع در زمینه خدمات ترجمه کتبی یا مترجم شفاهی، لطفاً با شماره تلفن مندرج در پشت کارت ID خود تماس بگیرید. (TTY/TDD:711).

**Hindi**
महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? यदि नहीं, तो हम किसी को इसे पढ़ने में आपकी सहायता करने के लिए रख सकते हैं। आप इस पत्र को अपनी भाषा में भी लिखवा सकते हैं। अनुवाद या दुभाषिया सेवाओं के संबंध में समय पर निःशुल्क सहायता के लिए कृपया अपने पहचान पत्र के पीछे दिए गए टेलीफोन नंबर पर कॉल करें। (TTY/TDD:711)।

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**Hmong**
TSEEM CEEB: Koj puas yeem nyeem tau tsab ntawv no? Yog tias nyeem tsis tau, peb mam kom lwm tus neeg los pab nyeem rau koj. Koj hais tau kom muab tsab ntawv no sau ua koj yam lus. Rau kev pab txhais ntawv los sis txhais lus pab dawb, kom raws sij hawm, thov hu tus npawb xov tooj nyob sab nraum qab ntawm koj daim npav ID. (TTY/TDD: 711).

**Japanese**
重要：この手紙は読めますか？そうでない場合は、誰かに読んでもらうのを手伝ってもらうこともできます。このお知らせは、貴方の言語で受け取ることも可能です。翻訳や通訳サービスの無料サポートをご希望の場合は、ID カードの裏面に記載されている電話番号までお電話ください。(TTY/TDD:711)。

**Khmer**
សំខាន់៖ តើអ្នកអាចអានសំបុត្រនេះបានទេ? បើអត់ទេ យើងអាចមានអ្នកជួយអ្នកឱ្យអានវាបាន។ អ្នកកាប្រហែលជាអាចឱ្យសំបុត្រនេះសរសេរជាភាសារបស់អ្នកបានផងដែរ។ ដើម្បីទទួលបានជំនួយដោយឥតគិតថ្លៃជាមួយនឹងការបកប្រែឬសេវាអ្នកបកប្រែផ្ទាល់មាត់ទាន់ពេលវេលា សូមទូរស័ព្ទទៅលេខនៅខាងក្រោយកាត ID របស់អ្នក។ (TTY/TDD:711)។

**Korean**
중요: 이 서신을 읽으실 수 있습니까? 그렇지 않다면 서신을 읽을 수 있게 도움을 드릴 수 있습니다. 원하시는 언어로 이 서신을 받으실 수도 있습니다. 번역이나 통역 서비스를 무료로 이용하시려면 적시에 ID 카드 뒷면에 있는 전화번호로 전화해 주십시오. (TTY/TDD: 711).

**Punjabi**
ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵੀ ਲਿਖਵਾ ਸਕਦੇ ਹੋ। ਅਨੁਵਾਦ ਜਾਂ ਦੁਭਾਸ਼ੀਏ ਸੇਵਾਵਾਂ ਵਿੱਚ ਮੁਫ਼ਤ ਮਦਦ ਲਈ, ਸਮੇਂ ਸਿਰ, ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਟੈਲੀਫੋਨ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD:711).

**Russian**
ВАЖНАЯ ИНФОРМАЦИЯ: Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Чтобы своевременно получить бесплатные услуги письменного или устного перевода, позвоните по номеру телефона, указанному на оборотной стороне вашей идентификационной карты участника. (TTY/TDD: 711).

**Tagalog**
MAHALAGA: Nababasa mo ba ang sulat na ito? Kung hindi, maaari kaming kumuha ng taong tutulong sa iyo na basahin ito. Maaari mo ring ipasulat ang sulat na ito sa iyong wika. Para sa libreng tulong sa mga pagsasalin o serbisyo ng interpreter, sa isang napapanahong paraan, mangyaring tawagan ang numero ng telepono sa likod ng iyong ID card. (TTY/TDD:711).

**Thai**
ข้อสำคัญ: คุณสามารถอ่านจดหมายฉบับนี้ได้หรือไม่ ถ้าไม่ เราสามารถหาคนช่วยอ่านให้กับคุณได้ นอกจากนี้คุณยังสามารถขอให้เขียนจดหมายให้ได้ในภาษาของคุณเอง ขอรับบริการแปลหรือล่ามที่รวดเร็วได้ฟรี กรุณาติดต่อหมายเลขโทรศัพท์ที่ด้านหลังของบัตรประจำตัวของคุณ (TTY/TDD:711).

**Vietnamese**
QUAN TRỌNG: Quý vị có thể đọc lá thư này không? Nếu không, chúng tôi có thể nhờ ai đó giúp quý vị đọc thư. Quý vị cũng có thể yêu cầu viết lá thư này bằng ngôn ngữ của mình. Để được trợ giúp miễn phí về dịch vụ biên dịch hoặc thông dịch một cách kịp thời, vui lòng gọi số điện thoại ở mặt sau thẻ ID của quý vị. (TTY/TDD: 711).

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

We follow state and federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services, in a timely manner, like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or if you think you were discriminated against based on race, color, national origin, age, disability, or sex, you can mail a complaint directly to 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. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

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