

# Your summary of benefits



Anthem® Blue Cross

Your Plan: Anthem PPO HSA-H 2000/2800/4000 20/40

Your Network: Prudent Buyer PPO

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b> <i>The deductible for In-Network and Non-Network are added separately and do not apply towards each other.</i>	\$2,000 individual \$2,800 member / \$4,000 family	\$6,000 individual \$6,000 member / \$12,000 family
<b>Out-of-Pocket Limit</b> <i>The Out-of-Pocket limit for In-Network and Non-Network are added separately and do not apply towards each other.</i>	\$3,000 individual \$3,000 member / \$6,000 family	\$9,000 individual \$9,000 member / \$18,000 family
The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both 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.		
<b>Preventive Care / Screening / Immunization</b>	No charge	40% coinsurance after deductible is met
<b><u>Doctor Home and Office Services</u></b>  <b>Primary Care Visit</b>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Specialist Care Visit</b>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Prenatal and Post-natal Care</b>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b><u>Other Practitioner Visits:</u></b>  Retail Health Clinic  Preferred On-line Visit <i>Includes Mental/Behavioral Health and Substance Abuse</i>  Manipulation Therapy <i>Coverage is limited to 30 visits per benefit period.</i>	20% coinsurance after deductible is met  \$10 copay per visit 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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Acupuncture <i>Coverage is limited to 20 visits per benefit period.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b><u>Other Services in an Office:</u></b>		
Allergy Testing	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Chemo/Radiation Therapy	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Dialysis/Hemodialysis	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 per visit member cost share per drug.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b><u>Diagnostic Services</u></b>		
<b>Lab:</b>		
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
<b>X-Ray:</b>		
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
<b>Advanced Diagnostic Imaging:</b>		
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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b><u>Emergency and Urgent Care</u></b> Urgent Care	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Emergency Room Facility Services	20% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	Covered as In-Network
<b><u>Ambulance</u></b>	20% coinsurance after deductible is met	Covered as In-Network
<b><u>Outpatient Mental/Behavioral Health and Substance Abuse</u></b> Doctor Office Visit	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Facility visit:</b> Facility Fees	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b><u>Outpatient Surgery</u></b> <b>Facility Fees:</b> Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Doctor and Other Services:</b> 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 a Non-Network Provider
<b><u>Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):</u></b> <b>Facility fees</b>  <b>Doctor and other services</b>	20% coinsurance after deductible is met  20% coinsurance after deductible is met	40% coinsurance after deductible is met  40% coinsurance after deductible is met
<b><u>Recovery &amp; Rehabilitation</u></b> <b>Home Health Care</b> <i>Coverage is limited to 100 visits per benefit period.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Rehabilitation services:</b>  Office <i>Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 40 visits per benefit period.</i>  Outpatient Hospital <i>Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 40 visits per benefit period.</i>	20% coinsurance after deductible is met  20% coinsurance after deductible is met	40% coinsurance after deductible is met  40% coinsurance after deductible is met
<b>Cardiac rehabilitation</b>  Office <i>Coverage is limited to 36 visits per benefit period.</i>  Outpatient Hospital <i>Coverage is limited to 36 visits per benefit period.</i>	20% coinsurance after deductible is met  20% coinsurance after deductible is met	40% coinsurance after deductible is met  40% 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	40% coinsurance after deductible is met
<b>Hospice</b>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Durable Medical Equipment</b>	50% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Prosthetic Devices</b>	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Pharmacy Deductible</b>	Combined with medical deductible	Combined with medical deductible
<b>Pharmacy Out of Pocket</b>	Combined with medical	Combined with medical
<b>Prescription Drug Coverage</b> <i>National with R90</i> <i>This plan uses an Essential Drug List.</i> <i>This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs. Drugs not on the list are not covered.</i>		
<b>Preventive Drugs</b> <i>This plan has Preventive RX coverage that allows the member designated Preventive drugs at the cost shares listed below.</i>		
Tier 1a - Typically Lower Cost Generic	No charge (retail and home delivery)	40% coinsurance up to \$250 per prescription after deductible is met (retail) and Not covered (home delivery)
Tier 1b – Typically Generic	No charge (retail and home delivery)	40% coinsurance up to \$250 per prescription after deductible is met (retail) and Not covered (home delivery)
Tier 2 - Typically Preferred Brand	No charge (retail and home delivery)	40% coinsurance up to \$250 per prescription after deductible is met (retail) and Not covered (home delivery)
<b>Tier 1a - Typically Lower Cost Generic</b> <i>30 day supply (retail pharmacy). 90 day supply (home delivery).</i>  <b>Tier 1b - Typically Generic</b> <i>30 day supply (retail pharmacy). 90 day supply (home delivery).</i>	\$5 copay per prescription after deductible is met (retail) and \$12.50 copay per prescription after deductible is met (home delivery)  \$15 copay per prescription after deductible is met	40% coinsurance up to \$250 per prescription after deductible is met (retail) and Not covered (home delivery)  40% coinsurance up to \$250 per prescription after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
	(retail) and \$37.50 copay per prescription after deductible is met (home delivery)	(retail) and Not covered (home delivery)
<b>Tier 2 – Typically Preferred Brand</b> <i>30 day supply (retail pharmacy). 90 day supply (home delivery).</i>	\$40 copay per prescription after deductible is met (retail) and \$120 copay per prescription after deductible is met (home delivery)	40% coinsurance up to \$250 per prescription after deductible is met (retail) and Not covered (home delivery)
<b>Tier 3 - Typically Non-Preferred Brand</b> <i>30 day supply (retail pharmacy). 90 day supply (home delivery).</i>	\$60 copay per prescription after deductible is met (retail) and \$180 copay per prescription after deductible is met (home delivery)	40% coinsurance up to \$250 per prescription after deductible is met (retail) and Not covered (home delivery)
<b>Tier 4 - Typically Specialty (brand and generic)</b> <i>30 day supply (retail pharmacy).</i>	30% coinsurance up to \$250 per prescription after deductible is met (retail and home delivery)	40% coinsurance up to \$250 per prescription after deductible is met (retail) and Not covered (home delivery)

**Notes:**

- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under “Outpatient Facility Services” which is generally coinsurance or coinsurance after your deductible is met.
- 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.
- Member is responsible for an additional \$500 copay if prior authorization is not obtained from Anthem for non-emergency admissions to Non-Network Providers. Anthem’s maximum payment is up to \$1,000 per day for non-emergency admissions to Non-Network Providers.
- Outpatient Facility tests and treatments are limited to \$350 per service for Non-Network Providers. Includes Diagnostic Services, X-ray, Surgery, Rehabilitation, Habilitation, and Cardiac Therapy. This also includes Surgery at Freestanding Facilities. Advanced Diagnostic Imaging is limited to \$800 per service for Non-Network Providers.

*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.*

Your Plan: Anthem PPO HSA-H 2000/2800/4000 20/40  
Your Network: Prudent Buyer PPO

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date

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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 لمساعدتك 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

ՌԻՇԱՄԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւ 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 مكتوب 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 យើងអាចផ្សព្វផ្សាយអត្ថបទនេះជូនអ្នក។ អ្នកក៏អាចទទួលបានលិខិតនេះដោយសេរីដោយសារតែអ្នកផងដែរ។ ដើម្បីទទួលបានជំនួយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមរយៈលេខ **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 **1-888-254-2721**로 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 ਿਕਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸੀਂ ਸ਼ਾਇਦ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਿਲਿਖਿਆ ਹੋਇਆ ਵੱਖੀ ਪ੍ਰਾਂਪ ੍ਰਾਂਪ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮਦਦ ਲਈ, ਿਕਰਪਾ ਕਰਕੇ ਫੋਰਨ **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

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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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