



Anthem

Blue Cross

High PPO

Your summary of benefits



Anthem® Blue Cross

Your Plan: Anthem Classic PPO 500/20/40/10

Your Network: Prudent Buyer PPO

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$500 person / \$1,500 family	\$1,500 person / \$4,500 family
Out-of-Pocket Limit	\$3,500 person / \$7,000 family	\$10,500 person / \$21,000 family
<p>The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per person 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 per person deductible or per person out-of-pocket maximum.</p> <p>Your copays, coinsurance and deductible count toward your out of pocket amount(s).</p> <p>In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other.</p>		
Preventive Care / Screening / Immunization	No charge	30% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	30% coinsurance after medical deductible is met
<p><u>Virtual Care (Telemedicine / Telehealth Visits)</u></p> <p>Virtual Visits - Online visits with Doctors who also provide services in person</p> <p>Primary Care (PCP)</p> <p>Mental Health and Substance Use Disorder care</p>	<p>\$20 copay per visit medical deductible does not apply</p> <p>\$20 copay per visit medical deductible does not apply</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>

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CA/LG/Anthem Classic PPO 500/20/40/10/6DPA/01-01-2022

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Specialist	\$40 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
<p>Virtual Visits from Online Provider LiveHealth Online via www.livehealthonline.com; our mobile app, website or Anthem-enabled device</p> <p>Primary Care (PCP) and Mental Health and Substance Use Disorder</p> <p>Specialist Care</p>	<p>\$0 copay per visit medical deductible does not apply</p> <p>\$40 copay per visit medical deductible does not apply</p>	
<p><u>Visits in an Office</u></p> <p>Primary Care (PCP)</p> <p>Specialist Care</p>	<p>\$20 copay per visit medical deductible does not apply</p> <p>\$40 copay per visit medical deductible does not apply</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>
<p><u>Other Practitioner Visits</u></p> <p>Routine Maternity Care (Prenatal and Postnatal)</p> <p>Retail Health Clinic</p> <p>Manipulation Therapy <i>Coverage is limited to 30 visits per benefit period.</i></p> <p>Acupuncture <i>Coverage is limited to 20 visits per benefit period.</i></p>	<p>\$20 copay per visit medical deductible does not apply</p> <p>\$20 copay per visit medical deductible does not apply</p> <p>\$20 copay per visit medical deductible does not apply</p> <p>\$20 copay per visit medical deductible does not apply</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>
<p><u>Other Services in an Office</u></p> <p>Allergy Testing</p>	<p>10% coinsurance after medical deductible is met</p>	<p>30% coinsurance after medical deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Chemo/Radiation Therapy</p> <p>Dialysis/Hemodialysis</p> <p>Prescription Drugs <i>Dispensed in the office</i> <i>Maximum of \$250 member cost share per drug.</i></p> <p>Surgery</p>	<p>10% coinsurance after medical deductible is met</p> <p>10% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p> <p>10% coinsurance after medical deductible is met</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>
<p><u>Diagnostic Services</u></p> <p>Lab</p> <p>Office</p> <p>Freestanding Lab</p> <p>Outpatient Hospital</p>	<p>10% coinsurance after medical deductible is met</p> <p>10% coinsurance after medical deductible is met</p> <p>10% coinsurance after medical deductible is met</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>
<p>X-Ray</p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>10% coinsurance after medical deductible is met</p> <p>10% coinsurance after medical deductible is met</p> <p>10% coinsurance after medical deductible is met</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i></p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>10% coinsurance after medical deductible is met</p> <p>10% coinsurance after medical deductible is met</p> <p>10% coinsurance after medical deductible is met</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>
<p><u>Emergency and Urgent Care</u></p> <p>Urgent Care</p> <p>Emergency Room Facility Services <i>Copay waived if admitted.</i></p> <p>Emergency Room Doctor and Other Services</p> <p>Ambulance</p>	<p>\$20 copay per visit medical deductible does not apply</p> <p>\$150 copay per visit and then 10% coinsurance after medical deductible is met</p> <p>10% coinsurance after medical deductible is met</p> <p>10% coinsurance after medical deductible is met</p>	<p>30% coinsurance after medical deductible is met</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p><u>Outpatient Mental Health and Substance Use Disorder</u></p> <p>Doctor Office Visit</p> <p>Facility Visit Facility Fees</p> <p>Doctor Services</p>	<p>\$20 copay per visit medical deductible does not apply</p> <p>10% coinsurance after medical deductible is met</p> <p>10% coinsurance after medical deductible is met</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><u>Outpatient Surgery</u></p> <p>Facility Fees</p> <p>Hospital</p> <p>Freestanding Surgical Center</p> <p>Doctor and Other Services</p> <p>Hospital</p>	<p>10% coinsurance after medical deductible is met</p> <p>10% coinsurance after medical deductible is met</p> <p>10% coinsurance after medical deductible is met</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>
<p><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder)</u></p> <p><i>Member is responsible for an additional \$500 copay if prior authorization is not obtained from Anthem for non-emergency Inpatient admissions to non-network providers. Anthem's maximum payment is up to \$1,000 per day for non-emergency Inpatient admissions to non-network providers.</i></p> <p>Facility Fees</p> <p>Doctor and other services</p>	<p>10% coinsurance after medical deductible is met</p> <p>10% coinsurance after medical deductible is met</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>
<p><u>Recovery & Rehabilitation</u></p> <p>Home Health Care</p> <p><i>Coverage is limited to 100 visits per benefit period.</i></p>	<p>10% coinsurance after medical deductible is met</p>	<p>30% coinsurance after medical deductible is met</p>
<p>Rehabilitation services</p> <p><i>Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 40 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 20 visits per benefit period.</i></p> <p>Office</p>	<p>10% coinsurance after medical deductible is met</p>	<p>30% coinsurance after medical deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Cardiac rehabilitation <i>Coverage is limited to 36 visits per benefit period.</i>		
Office	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Outpatient Hospital	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Skilled Nursing Care (facility) <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.</i>	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Inpatient Hospice	No charge	30% coinsurance after medical deductible is met
Durable Medical Equipment	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Prosthetic Devices	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Prescription Drug Coverage <i>Cost shares for drugs included on the Essential drug list appear below. Drugs not included on the Essential drug list will not be covered. Your plan uses the Base Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies.</i>		

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<p>Home Delivery Pharmacy Maintenance medication are available through IngenioRx 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.</p>		
<p>Tier 1a - Typically Lower Cost Generic Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</p>	<p>\$5 copay per prescription (retail) and \$12.50 copay per prescription (home delivery)</p>	<p>50% coinsurance up to \$250 per prescription (retail) and Not covered (home delivery)</p>
<p>Tier 1b - Typically Generic Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</p>	<p>\$15 copay per prescription (retail) and \$37.50 copay per prescription (home delivery)</p>	<p>50% coinsurance up to \$250 per prescription (retail) and Not covered (home delivery)</p>
<p>Tier 2 – Typically Preferred Brand Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</p>	<p>\$30 copay per prescription (retail) and \$90 copay per prescription (home delivery)</p>	<p>50% coinsurance up to \$250 per prescription (retail) and Not covered (home delivery)</p>
<p>Tier 3 - Typically Non-Preferred Brand Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</p>	<p>\$50 copay per prescription (retail) and \$150 copay per prescription (home delivery)</p>	<p>50% coinsurance up to \$250 per prescription (retail) and Not covered (home delivery)</p>
<p>Tier 4 - Typically Specialty (brand and generic) Per 30 day supply (specialty pharmacy).</p>	<p>30% coinsurance up to \$250 per prescription (retail and home delivery)</p>	<p>50% coinsurance up to \$250 per prescription (retail) and Not covered (home delivery)</p>

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><i>This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.</i></p>		
<p><u>Children's Vision (up to age 19)</u> Child Vision Deductible</p>	<p>\$0 person</p>	<p>\$0 person</p>
<p>Vision exam <i>Limited to 1 exam per benefit period.</i></p>	<p>No charge</p>	<p>\$0 copayment up to plan's Maximum Allowed Amount</p>
<p><u>Adult Vision (age 19 and older)</u></p>		

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Adult Vision Deductible	\$0 person	\$0 person
Vision exam <i>Limited to 1 exam per benefit period.</i>	No charge	Reimbursed Up to \$42

Notes:

- You are encouraged to select a Primary Care Physician (PCP). Choosing a PCP is an important decision. Call us at the number on your ID card and we'll help you pick a doctor.
- 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".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- Outpatient Facility tests and treatments are limited to \$350 per admission 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.
- 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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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

ՌԻՇԱԴՐՈՒԹՅՈՒՆ. 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 យើងអាចឱ្យនរណាម្នាក់អានជូនអ្នក។ អ្នកក៏អាចទទួលបានលិខិតនេះដោយសរសេរជាភាសាបស្ចឹមផងដែរ។ ដើម្បីទទួលបានជំនួយភតគិតផ្លូវ 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 ਸ਼ਾਇਦ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵੱਖੀ ਪੜ੍ਹਾ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਫੌਰਨ 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 ท่านยังสามารถให้เจ้าหน้าที่ช่วยเขียนจดหมายในภาษาของท่านอีกด้วย 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
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