

Your summary of benefits



Anthem® Blue Cross

Your Plan: Blue Diamond Growers: Custom Anthem Prudent Buyer PPO Classic 2000/10/30

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	10% coinsurance after medical deductible is met
Mental Health & Substance Use Disorder Services	10% coinsurance after medical deductible is met
Specialist care	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	\$2,000 person / \$4,000 family	\$4,000 person / \$8,000 family
Overall Out-of-Pocket Limit	\$3,000 person / \$6,000 family	\$6,000 person / \$12,000 family
<p>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.</p> <p>All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit.</p> <p>In-Network and Out-of-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.</p>		
Doctor Visits (virtual and office) <i>You are encouraged to select a Primary Care Physician (PCP).</i>		
Primary Care (PCP) and Mental Health and Substance Use Disorder Services <i>virtual and office</i>	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Specialist Care <i>virtual and office</i>	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
<u>Other Practitioner Visits</u>		
Maternity services		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Prenatal and Postnatal care	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Delivery	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i>	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Manipulation Therapy	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Acupuncture <i>Coverage is limited to 20 visits per benefit period.</i>	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
<u>Other Services in an Office</u>		
Allergy Testing	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Prescription Drugs <i>Dispensed in the office</i>	Not covered	Not covered
Surgery	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Preventive care / screenings / immunizations	No charge	Not covered
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	Not covered	Not covered
<u>Diagnostic Services</u>		
Lab		
Office	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Freestanding Lab	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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
X-Ray		
Office	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Freestanding Radiology Center	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
Advanced Diagnostic Imaging for example: MRI, PET and CAT scans		
Office	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Freestanding Radiology Center	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
<u>Emergency and Urgent Care</u>		
<i>Urgent Care includes doctor services. Additional charges may apply depending on the care provided.</i>	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Emergency Room Facility Services	10% coinsurance after medical deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	10% coinsurance after medical deductible is met	Covered as In-Network
Ambulance	10% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Doctor Services	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
<u>Outpatient Surgery</u> Facility Fees Hospital Ambulatory Surgical Center Physician and other services <i>including surgeon fees</i> Hospital	10% coinsurance after medical deductible is met 10% coinsurance after medical deductible is met 10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met 30% coinsurance after medical deductible is met 30% coinsurance after medical deductible is met
<u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u> Facility Fees Physician and other services <i>including surgeon fees</i>	10% coinsurance after medical deductible is met 10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met 30% coinsurance after medical deductible is met
Home Health Care <i>Coverage is limited to 100 visits per benefit period.</i>	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Rehabilitation services <i>including physical, occupational and speech therapies</i> . Habilitation services are not covered. <i>Coverage for physical therapy is limited to 20 visits per benefit period.</i> <i>Coverage for speech therapy is limited to 20 visits per benefit period.</i> <i>Coverage for occupational therapy is limited to 20 visits per benefit period.</i> Office Outpatient Hospital	10% coinsurance after medical deductible is met 10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met 30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Pulmonary rehabilitation <i>office and outpatient hospital</i>	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Cardiac rehabilitation <i>office and outpatient hospital</i> <i>Coverage is limited to 36 visits per benefit period.</i>	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Dialysis/Hemodialysis <i>office and outpatient hospital</i>	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Chemo/Radiation Therapy <i>office and outpatient hospital</i>	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Skilled Nursing Care (facility) <i>Coverage is limited to 60 days per benefit period.</i>	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Inpatient Hospice	10% coinsurance after medical deductible is met	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
Hearing aids <i>Coverage is limited to \$2,500 per benefit period.</i>	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Infertility coverage is limited to: <ul style="list-style-type: none"> <i>Intrauterine Insemination (IUI) is limited to three (3) cycles per Member's lifetime.</i> <i>In-Vitro Fertilization (IVF) is limited to one (1) per Member's lifetime.</i> <i>Infertility services does not apply to Out-of-Pocket.</i>	50% 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	Not applicable	Not applicable
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: <i>Base Network</i> Drug List: <i>National Direct Plus</i> <i>If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.</i>		
Day Supply Limits: Retail Pharmacy 30 day supply <i>(cost shares noted below)</i> Retail 90 Pharmacy 90 day supply <i>(3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).</i> Home Delivery Pharmacy 90 day supply <i>(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.</i> Specialty Pharmacy 30 day supply <i>(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.</i>		
Tier 1 - Typically Generic	\$10 copay per prescription (retail) and \$20 copay per prescription (home delivery)	50% coinsurance up to \$250 per prescription (retail) and Not covered (home delivery)
Tier 2 - Typically Preferred Brand	\$25 copay per prescription (retail) and \$50 copay per prescription (home delivery)	50% coinsurance up to \$250 per prescription (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	\$40 copay per prescription (retail) and \$80 copay per prescription (home delivery)	50% coinsurance up to \$250 per prescription (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	30% coinsurance up to \$100 per prescription (retail and home delivery)	50% coinsurance up to \$250 per prescription (retail) and Not covered (home delivery)
Infertility Drugs <i>Lifetime Maximum: \$15,000</i>	Cost share will be indicated at Rx Tier Level	Cost share will be indicated at Rx Tier Level

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.

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

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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

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. 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 យើងអាចជួយអ្នកក្នុងការអានលិខិតនេះ។ អ្នកក៏អាចទទួលបានលិខិតនេះដោយសេរីដោយសារតែភាសាដែលអ្នកផ្ទេរ។ ដើម្បីទទួលបានជំនួយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខ 1-888-254-2721។ (TTY/TDD: 711)

Korean

중요 : 이 편지를 읽으실 수 있습니까? 읽지 못하는 경우에는, 내용을 이해하기 위한 지원을 받을 수 있습니다. 또한, 이 편지를 원하는 언어로 작성한 것을 받을 수도 있습니다. 다음 번호에 지금 전화하여, 무료 지원을 받으십시오.
1-888-254-2721 (TTY/TDD: 711)

Punjabi

ਮਹੱਤਵਪੂਰਨ : ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਤੁਹਾਨੂੰ ਇਹ ਪੱਤਰ ਸਮਝਣ ਵਿੱਚ ਮਦਦ ਕਰ ਸਕਦੇ ਹਾਂ। ਇਸਦੀ ਕਾਪੀ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵੀ ਮਿਲ ਸਕਦੀ ਹੈ। ਇਹ ਸੇਵਾ ਮੁਫ਼ਤ ਹੈ। ਸਹਾਇਤਾ ਲਈ ਸੰਪਰਕ ਕਰੋ 1-888-254-2721
(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 โปรดโทรติดต่อที่ หมายเลข 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>.

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