

Your summary of benefits

Anthem® Blue Cross

Your Contract Code: 4HW6

Your Plan: Anthem Gold PPO 20/30%

Your Network: Prudent Buyer PPO

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.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible <i>See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.</i>	\$0 person / \$0 family	\$2,000 person / \$4,000 family
Out-of-Pocket Limit <i>When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.</i>	\$7,000 person / \$14,000 family	\$14,000 person / \$28,000 family
Preventive care/screening/immunization <i>In-network preventive care is not subject to deductible, if your plan has a deductible.</i>	No charge	50% coinsurance after deductible is met
Doctor Home and Office Services Primary Care Visit to treat an injury or illness	\$20 copay per visit	50% coinsurance after deductible is met
Specialist Care Visit	\$50 copay per visit	50% coinsurance after deductible is met
Prenatal Preventive Care	No charge	50% coinsurance after deductible is met

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Post-natal Office Visit	\$20 copay per visit	50% coinsurance after deductible is met
Other Practitioner Visits: Retail Health Clinic Visit On-line visit: Preferred On-line Visit <i>Live Health Online is the preferred telehealth solution (www.livehealthonline.com). Includes Medical, Mental Health and Substance Use.</i> Chiropractic/Manipulation Therapy <i>Coverage is limited to 20 visits per year. Applies to In-Network. Visit limits are combined both across outpatient and other professional visits.</i> Acupuncture	\$20 copay per visit No charge for 3 visits, \$5 after 3 visits 50% coinsurance \$20 copay per visit	50% coinsurance after deductible is met 50% coinsurance after deductible is met Not covered Not covered
Other Services in an Office: Allergy Testing Chemo/Radiation Therapy Hemodialysis Drugs Administered in the Office <i>For the drugs itself dispensed in the office through infusion/injection.</i>	30% coinsurance 30% coinsurance 30% coinsurance 30% coinsurance	50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met

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<p>Diagnostic Services</p> <p>Lab:</p> <p>Office</p> <p>Outpatient Hospital <i>Anthem's maximum payment is up to \$380 per service for Non-Network Providers.</i></p> <p>Freestanding Lab/Reference Lab</p>	<p>\$20 copay per service</p> <p>30% coinsurance</p> <p>\$20 copay per service</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>X-Ray:</p> <p>Office</p> <p>Outpatient Hospital <i>Anthem's maximum payment is up to \$380 per service for Non-Network Providers.</i></p>	<p>\$50 copay per service</p> <p>30% coinsurance</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p>Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):</p> <p>Office <i>Anthem's maximum payment is up to \$800 per service for Non-Network Providers.</i></p> <p>Outpatient Hospital <i>Anthem's maximum payment is up to \$380 per admission for non-network providers.</i></p>	<p>30% coinsurance</p> <p>\$100 copay per service and 30% coinsurance</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p>Emergency and Urgent Care</p> <p>Urgent Care (Office Setting)</p>	<p>\$50 copay per visit</p>	<p>50% coinsurance after deductible is met</p>
<p>Emergency Room Facility Services <i>Emergency Room copay is waived if directly admitted to the hospital.</i></p>	<p>\$250 copay per visit and 30% coinsurance</p>	<p>Covered as In-Network</p>

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<p>Emergency Room Doctor and Other Services</p>	30% coinsurance	Covered as In-Network
<p>Ambulance Transportation <i>Non-emergency, Non-Network air ambulance services are limited to Anthem maximum payment of \$50,000 per trip.</i></p>	30% coinsurance	Covered as In-Network
<p>Outpatient Mental Health and Substance Use Disorder</p> <p>Doctor Office Visit</p> <p>Facility visit:</p> <p> Facility Fees</p> <p> Doctor Services</p>	<p>\$20 copay per visit</p> <p>30% coinsurance</p> <p>30% coinsurance</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>Outpatient Surgery</p> <p>Facility Fees:</p> <p> Hospital <i>Anthem's maximum payment is up to \$380 per service for Non-Network Providers.</i></p> <p>Doctor and Other Services:</p> <p> Hospital</p>	<p>30% coinsurance</p> <p>30% coinsurance</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)</p> <p>Facility fees (for example, room & board) <i>Coverage for Inpatient Rehabilitation is limited to 100 days per benefit period. Limit is combined across a skilled nursing facility and inpatient rehabilitation facility (includes services in an outpatient day rehabilitation program). Anthem's maximum payment is up to \$650 per day for non-network providers. Limit is combined In-Network and Non-Network.</i></p> <p>Doctor and other services</p>	<p>30% coinsurance</p> <p>30% coinsurance</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p>Recovery & Rehabilitation</p> <p>Home Health Care <i>Coverage is limited to 100 visits per year. Limit is combined In-Network and Non-Network. Limit does not apply to separate Physical or Occupational or Speech Therapy limits, when performed as part of Home Health. A visit equals 4 hours or less of care. Limits are combined for home health care and private duty nursing. Anthem's maximum payment is up to \$75 per visit for non-network.</i></p>	<p>30% coinsurance</p>	<p>50% coinsurance after deductible is met</p>
<p>Rehabilitation services (for example, physical/speech/occupational therapy):</p> <p>Office</p> <p>Outpatient Hospital <i>Anthem's maximum payment is up to \$380 per admission for non-network providers.</i></p>	<p>\$20 copay per visit</p> <p>30% coinsurance</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p>Habilitation services (for example, physical/speech/occupational therapy):</p> <p>Office</p> <p>Outpatient Hospital <i>Anthem's maximum payment is up to \$380 per admission for non-network providers.</i></p>	<p>\$20 copay per visit</p> <p>30% coinsurance</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Cardiac rehabilitation Office</p> <p>Outpatient Hospital <i>Limit is combined In-Network and Non-Network across all outpatient settings. Anthem's maximum payment is up to \$380 per admission for non-network providers.</i></p>	<p>\$20 copay per visit</p> <p>30% coinsurance</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p>Skilled Nursing Care (in a facility) <i>Coverage is limited to 100 days per benefit period. Limit is combined In-Network and Non-Network. Anthem's maximum payment is up to \$150 per day for admissions to non-network providers. Coverage for Skilled Nursing and Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 100 days combined per benefit period.</i></p>	<p>30% coinsurance</p>	<p>50% coinsurance after deductible is met</p>
<p>Hospice</p>	<p>No charge</p>	<p>50% coinsurance after deductible is met</p>
<p>Durable Medical Equipment</p>	<p>50% coinsurance</p>	<p>50% coinsurance after deductible is met</p>

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Pharmacy Deductible</p> <p>Additional deductible: <i>Applies to Tier 2, Tier 3 and Tier 4 Prescription Drugs</i></p>	\$150 person / \$300 family	Not covered
<p>Pharmacy Out of Pocket</p>	Combined with medical out of pocket maximum	Not covered
<p>Prescription Drug Coverage <i>Select Drug List</i> <i>This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.</i></p>		
<p>Tier 1 - Typically Generic <i>Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.</i></p>	\$15 copay per prescription, Pharmacy deductible does not apply (retail) and \$38 copay per prescription, Pharmacy deductible does not apply (home delivery)	Not covered (retail and home delivery)
<p>Tier 2 – Typically Preferred Brand <i>Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.</i></p>	\$40 copay per prescription after Pharmacy deductible is met (retail) and \$120 copay per prescription after Pharmacy deductible is met (home delivery)	Not covered (retail and home delivery)
<p>Tier 3 - Typically Non-Preferred Brand</p>	\$80 copay per prescription after Pharmacy	Not covered (retail and home delivery)

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><i>Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.</i></p>	<p>deductible is met (retail) and \$240 copay per prescription after Pharmacy deductible is met (home delivery)</p>	
<p>Tier 4 - Typically Specialty (brand and generic) <i>Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program).</i></p>	<p>30% coinsurance up to \$250 per prescription after Pharmacy deductible is met (retail and home delivery)</p>	<p>Not covered (retail and home delivery)</p>

Your summary of benefits

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. Not all cost shares for covered services are shown below. Benefits include coverage for member's choice of eyeglass lenses or contact lenses, but not both. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/ Disclosure form/ Certificate. If there is a difference between this summary and either Evidence of Coverage/ Disclosure form/ Certificate, the Evidence of Coverage/ Disclosure form/ Certificate will prevail.</i></p> <p><i>Only children's vision services count towards your out of pocket limit.</i></p>		
<p>Children's Vision Essential Health Benefits (up to age 19)</p> <p>Child Vision Deductible</p> <p>Vision exam <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.</i></p>	<p>Not Applicable \$0 copay</p>	<p>Not Applicable \$0 copayment up to plan's Maximum Allowed Amount</p>
<p>Frames <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>\$0 copayment up to plan's Maximum Allowed Amount</p>
<p>Single Vision Lenses <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i></p>	<p>\$0 copay</p>	<p>Reimbursed up to \$25</p>
<p>Bifocal Vision Lenses <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i></p>	<p>\$0 copay</p>	<p>Reimbursed up to \$40</p>
<p>Trifocal Vision Lenses <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i></p>	<p>\$0 copay</p>	<p>Reimbursed up to \$55</p>
<p>Elective contact lenses <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>\$0 copayment up to plan's Maximum Allowed Amount</p>
<p>Non-Elective Contact Lenses <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>\$0 copayment up to plan's Maximum Allowed Amount</p>
<p>Adult Vision (age 19 and older)</p>		

Your summary of benefits

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Adult Vision Deductible Vision exam <i>Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.</i>	Not Applicable \$20 copay	Not Applicable Reimbursed Up to \$30
Frames	Not covered	Not covered
Single Vision Lenses	Not covered	Not covered
Bifocal Vision Lenses	Not covered	Not covered
Trifocal Vision Lenses	Not covered	Not covered
Elective contact lenses	Not covered	Not covered
Non-Elective Contact Lenses	Not covered	Not covered

Your summary of benefits

Covered Dental 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 dental coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/ Disclosure form/ Certificate. If there is a difference between this summary and either Evidence of Coverage/ Disclosure form/ Certificate, the Evidence of Coverage/ Disclosure form/ Certificate will prevail.</i></p> <p><i>Only children's dental services count towards your out of pocket limit.</i></p>		
Children's Dental Essential Health Benefits Diagnostic and preventive Coverage for In-Network Providers and Non-Network Providers is limited to 1 visit per 6 months.	0% coinsurance	0% coinsurance after deductible is met
Basic services	50% coinsurance	50% coinsurance after deductible is met
Major services	50% coinsurance	50% coinsurance after deductible is met
Medically Necessary Orthodontia services	50% coinsurance	50% coinsurance after deductible is met
Cosmetic Orthodontia services	Not covered	Not covered
Deductible	Not applicable	Combined with medical deductible
Adult Dental		
Diagnostic and preventive	Not covered	Not covered
Basic services	Not covered	Not covered
Major services	Not covered	Not covered
Deductible	Not covered	Not covered
Annual maximum	Not covered	Not covered

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Notes:

- 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.
- If your plan includes a hospital stay copay and you are readmitted within 72 hours of a prior admission for the same diagnosis, your hospital stay copay for your readmission is waived.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- For additional information on this plan, please visit www.sbc.anthem.com to obtain a “Summary of Benefits and Coverage”.
- If services are rendered by a non-participating provider and your plan includes out of network benefits, you may be responsible for any difference between the covered plan payment and the actual non-participating providers charge.
- For plans with an office visit copay, the copay applies to the actual office visit and additional cost shares may apply for any other service performed in the office (i.e., X-ray, lab, surgery), after any applicable deductible.
- Certain services are subject to the utilization review program or precertification. Before scheduling services, the member must make sure utilization or precertification review is obtained. If utilization or precertification review is not obtained, benefits may be reduced or not paid according to the plan.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- All medical and pharmacy deductibles, copayments and coinsurance apply to the out of pocket maximum.
- This health plan includes an Employee Assistance Program (EAP) with myStrength to support your emotional health and wellness with resources including one-on-one counseling by phone, in person and online, virtual visits through LiveHealth Online. Three visits are provided at no charge and 24/7, 365 days of support on the go.

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Questions: (855) 383-7248 or visit us at www.anthem.com/ca
CA/SG/Anthem Gold PPO 20/30%/4HW6/01-01-2020

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)

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Japanese

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 យើងអាចឲ្យមនុស្សណាម្នាក់អានវាជូនអ្នក។ អ្នកក៏អាចទទួលលិខិតនេះដោយសេរីដោយឥតគិតថ្លៃ។ ដើម្បីទទួលបានជំនួយឥតគិតថ្លៃ 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 ਪੜ੍ਹਾਉਣ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਿਕਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸੀਂ ਸਾਇਦ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਿਲਿਖਿਆ ਹੋਇਆ ਵੱਖੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮਦਦ ਲਈ, ਿਕਰਪਾ 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 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)

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