

# Your summary of benefits



Anthem® Blue Cross

Your Plan: Producers' Health Benefits Plan: Modified Classic PPO 500/30/20

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>	\$500 person / \$1,000 family	\$1,500 person / \$3,000 family
<b>Out-of-Pocket Limit</b>	\$5,000 person / \$10,000 family	\$14,000 person / \$28,000 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>		
<b>Preventive Care / Screening / Immunization</b>	No charge	50% coinsurance after deductible is met
<b>Preventive Care for Chronic Conditions</b> <i>per IRS guidelines</i>	No charge	50% coinsurance after deductible is met
<b><u>Virtual Care (Telemedicine / Telehealth Visits)</u></b>		
<b>Virtual Visits - Online visits with Doctors who also provide services in person</b>		
Primary Care (PCP)	\$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Mental Health and Substance Use Disorder care	\$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Specialist	\$30 copay per visit deductible does not apply	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>Virtual Visits from Online Provider LiveHealth Online</b> via <a href="http://www.livehealthonline.com">www.livehealthonline.com</a>; 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>\$10 copay per visit deductible does not apply</p> <p>\$30 copay per visit deductible does not apply</p>	
<p><b><u>Visits in an Office</u></b></p> <p><b>Primary Care (PCP)</b></p> <p><b>Specialist Care</b></p>	<p>\$30 copay per visit deductible does not apply</p> <p>\$30 copay per visit deductible does not apply</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><b><u>Other Practitioner Visits</u></b></p> <p><b>Routine Maternity Care</b> (Prenatal and Postnatal)</p> <p><b>Retail Health Clinic</b></p> <p><b>Manipulation Therapy</b> <i>Coverage is limited to 30 visits per benefit period.</i></p> <p><b>Acupuncture</b> <i>Coverage is limited to 20 visits per benefit period.</i></p>	<p>\$30 copay per visit deductible does not apply</p> <p>\$30 copay per visit deductible does not apply</p> <p>\$30 copay per visit deductible does not apply</p> <p>\$30 copay per visit deductible does not apply</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>50% coinsurance after deductible is met</p>
<p><b><u>Other Services in an Office</u></b></p> <p><b>Allergy Testing</b></p> <p><b>Chemo/Radiation Therapy</b></p> <p><b>Dialysis/Hemodialysis</b></p> <p><b>Prescription Drugs</b> <i>Dispensed in the office</i> <i>Maximum of \$250 member cost share per drug.</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</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>50% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Surgery</b>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b><u>Diagnostic Services</u></b> <b>Lab</b> Office Freestanding Lab Outpatient Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met
<b>X-Ray</b> Office Freestanding Radiology Center Outpatient Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met
<b>Advanced Diagnostic Imaging</b> <i>for example: MRI, PET and CAT scans</i> Office Freestanding Radiology Center Outpatient Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met
<b><u>Emergency and Urgent Care</u></b> <b>Urgent Care</b>  <b>Emergency Room Facility Services</b> <i>Copay waived if admitted.</i>  <b>Emergency Room Doctor and Other Services</b>	\$30 copay per visit deductible does not apply  \$150 copay per admission and then 20% coinsurance after deductible is met  20% coinsurance after deductible is met	50% coinsurance after deductible is met  Covered as In-Network  Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Ambulance</b>	20% coinsurance after deductible is met	Covered as In-Network
<u><b>Outpatient Mental Health and Substance Use Disorder</b></u> <b>Doctor Office Visit</b>  <b>Facility Visit</b> Facility Fees  Doctor Services	\$30 copay per visit deductible does not apply  20% coinsurance after deductible is met  20% coinsurance after deductible is met	Covered as In-Network  50% coinsurance after deductible is met  50% coinsurance after deductible is met  50% coinsurance after deductible is met
<u><b>Outpatient Surgery</b></u> <b>Facility Fees</b> Hospital  Freestanding Surgical Center  <b>Doctor and Other Services</b> Hospital	\$125 copay per visit and then 20% coinsurance after deductible is met  \$125 copay per visit and then 20% coinsurance after deductible is met  20% coinsurance after deductible is met	50% coinsurance after deductible is met  50% coinsurance after deductible is met  50% coinsurance after deductible is met
<u><b>Hospital (Including Maternity, Mental Health and Substance Use Disorder)</b></u> <i>Anthem's maximum payment is up to \$1,000 per day for non-emergency Inpatient admissions to non-network providers.</i> <b>Facility Fees</b>  <b>Doctor and other services</b>	\$500 copay per admission and then 20% coinsurance after deductible is met  20% coinsurance after deductible is met	50% coinsurance after deductible is met  50% coinsurance after deductible is met
<u><b>Recovery &amp; Rehabilitation</b></u> <b>Home Health Care</b> <i>Coverage is limited to 100 visits per benefit period.</i>	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 a Non-Network Provider
<b>Rehabilitation services</b> Office Outpatient Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met
<b>Cardiac rehabilitation</b> Office Outpatient Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met
<b>Skilled Nursing Care (facility)</b> <i>Coverage is limited to 100 days per benefit period.</i>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Inpatient Hospice</b>	No charge	50% coinsurance after deductible is met
<b>Durable Medical Equipment</b>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Prosthetic Devices</b>	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 a Non-Network Pharmacy
<b>Pharmacy Deductible</b>	Not applicable	Not applicable
<b>Pharmacy Out-of-Pocket Limit</b>	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
<b>Prescription Drug Coverage</b> <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>		
<b>Home Delivery Pharmacy</b> <i>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.</i>		

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<p><b>Tier 1a - Typically Lower Cost Generic</b>  <i>Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</i></p> <p><b>Tier 1b - Typically Generic</b>  <i>Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</i></p>	<p>\$10 copay per prescription, deductible does not apply (retail) and \$20 copay per prescription, deductible does not apply (home delivery)</p> <p>\$30 copay per prescription, deductible does not apply (retail) and \$50 copay per prescription, deductible does not apply (home delivery)</p>	<p>50% coinsurance up to \$250 per prescription, deductible does not apply (retail) and Not covered (home delivery)</p> <p>50% coinsurance up to \$250 per prescription, deductible does not apply (retail) and Not covered (home delivery)</p>
<p><b>Tier 2 – Typically Preferred Brand</b>  <i>Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</i></p>	<p>\$50 copay per prescription, deductible does not apply (retail) and \$120 copay per prescription, deductible does not apply (home delivery)</p>	<p>50% coinsurance up to \$250 per prescription, deductible does not apply (retail) and Not covered (home delivery)</p>
<p><b>Tier 3 - Typically Non-Preferred Brand</b>  <i>Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</i></p>	<p>\$75 copay per prescription, deductible does not apply (retail) and \$225 copay per prescription, deductible does not apply (home delivery)</p>	<p>50% coinsurance up to \$250 per prescription, deductible does not apply (retail) and Not covered (home delivery)</p>
<p><b>Tier 4 - Typically Specialty (brand and generic)</b>  <i>Per 30 day supply (specialty pharmacy).</i></p>	<p>30% coinsurance up to \$250 per prescription, deductible does not apply (retail and home delivery)</p>	<p>50% coinsurance up to \$250 per prescription, deductible does not apply (retail) and Not covered (home delivery)</p>

**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”.
- 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 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.
- 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.*

## Your Plan: Producers' Health Benefits Plan: Modified Classic PPO

### 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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Questions: (855) 333-5730 or visit us at [www.anthem.com/ca](http://www.anthem.com/ca)

CA/LG/Producers' Health Benefits Plan: Modified Classic PPO/48C4/01-01-2022



# 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 យើងអាចឲ្យមនុស្សណាម្នាក់អានជូនអ្នក។ អ្នកក៏អាចទទួលបានលិខិតនេះដោយសេរីសេរីជាភាសាមរបស់អ្នកផងដែរ។ 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 ਪੜ੍ਹ ਕੇ ਿਵੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਿਕਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸੀਂ ਸਾਇਦ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਿਵੱਚ ਿਲਿਖਿਆ ਹੋਇਆ ਵੱਖੀ ਪੜ੍ਹਾ ਾਪ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮਦਦ ਲਈ, ਿਕਰਪਾ ਕਰਕੇ ਫੋਨ 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

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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>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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