

# Your summary of benefits



Anthem® Blue Cross Life and Health Insurance Company

Your Plan: PACE: Modified Classic PPO 250/20/10

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	No charge
Mental Health & Substance Use Disorder Services	No charge
Specialist care	\$20 copay per visit deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$250 person / \$750 family	\$250 person / \$750 family
Overall Out-of-Pocket Limit	\$2,500 person / \$5,000 family	\$6,500 person / \$13,000 family

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.

All medical deductibles, copayments and coinsurance apply to the out-of-pocket limit.

In-Network and Non-Network deductibles are combined and accumulate toward each other; however In-Network and Non-Network out-of-pocket limit amounts accumulate separately and do not accumulate toward each other.

**Doctor Visits (virtual and office)** *You are encouraged to select a Primary Care Physician (PCP).*

<b>Primary Care (PCP) and Mental Health and Substance Use Disorder Services</b> <i>virtual and office</i>	\$20 copay per visit deductible does not apply	30% coinsurance after deductible is met
<b>Specialist Care</b> <i>virtual and office</i>	\$20 copay per visit deductible does not apply	30% 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><u>Other Practitioner Visits</u></b></p> <p><b>Routine Maternity Care</b> (Prenatal and Postnatal)</p> <p><b>Retail Health Clinic</b> for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</p> <p><b>Manipulation Therapy</b> Coverage is limited to 30 visits per benefit period.</p> <p><b>Acupuncture</b> Coverage is limited to 20 visits per benefit period.</p>	<p>\$20 copay per visit deductible does not apply</p> <p>\$20 copay per visit deductible does not apply</p> <p>\$20 copay per visit deductible does not apply</p> <p>\$20 copay per visit deductible does not apply</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% 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>Prescription Drugs</b> Dispensed in the office Maximum of \$250 member cost share per drug.</p> <p><b>Surgery</b></p>	<p>10% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><b>Preventive care / screenings / immunizations</b></p>	<p>No charge</p>	<p>30% coinsurance after deductible is met</p>
<p><b>Preventive Care for Chronic Conditions</b> per IRS guidelines</p>	<p>No charge</p>	<p>30% coinsurance after deductible is met</p>
<p><b><u>Diagnostic Services</u></b></p> <p><b>Lab</b></p> <p>Office</p> <p>Freestanding Lab</p> <p>Outpatient Hospital</p>	<p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><b>X-Ray</b></p> <p>Office</p> <p>Freestanding Radiology Center</p>	<p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% 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
Outpatient Hospital	10% coinsurance after deductible is met	30% coinsurance after deductible is met
<p><b>Advanced Diagnostic Imaging</b> <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 deductible is met</p> <p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><b><u>Emergency and Urgent Care</u></b></p> <p><b>Urgent Care</b> <i>includes doctor services. Additional charges may apply depending on the care provided.</i></p> <p><b>Emergency Room Facility Services</b> <i>\$150 deductible waived if admitted directly from ER</i></p> <p><b>Emergency Room Doctor and Other Services</b></p> <p><b>Ambulance</b> <i>Authorized Non-Network non-emergency ambulance services are limited to an Anthem maximum payment of \$50,000 per trip.</i></p>	<p>\$20 copay per visit deductible does not apply</p> <p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p><b>Outpatient Mental Health and Substance Use Disorder Services at a Facility</b></p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><b><u>Outpatient Surgery</u></b></p> <p><b>Facility Fees</b></p> <p>Hospital</p> <p>Ambulatory Surgical Center</p> <p><b>Physician and other services</b> <i>including surgeon fees</i></p> <p>Hospital</p>	<p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% 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
<p><b><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u></b>  <i>Anthem's maximum payment is up to \$1,000 per day for non-emergency inpatient admissions to non-network providers.</i></p> <p><b>Facility Fees</b></p> <p><b>Physician and other services</b> <i>including surgeon fees</i></p>	<p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><b>Home Health Care</b>  <i>Coverage is limited to 100 visits per benefit period.</i></p>	<p>10% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p><b>Rehabilitation and Habilitation services</b> <i>including physical, occupational and speech therapies.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><b>Pulmonary rehabilitation</b> <i>office and outpatient hospital</i></p>	<p>10% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p><b>Cardiac rehabilitation</b> <i>office and outpatient hospital</i></p>	<p>10% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p><b>Dialysis/Hemodialysis</b> <i>office and outpatient hospital</i></p>	<p>10% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p><b>Chemo/Radiation Therapy</b> <i>office and outpatient hospital</i></p>	<p>10% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p><b>Skilled Nursing Care (facility)</b>  <i>Coverage is limited to 100 days per benefit period.</i></p>	<p>10% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p><b>Inpatient Hospice</b></p>	<p>No charge</p>	<p>30% coinsurance after deductible is met</p>
<p><b>Durable Medical Equipment</b></p>	<p>10% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p><b>Prosthetic Devices</b></p>	<p>10% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Not covered	Not covered
Pharmacy Out-of-Pocket Limit	Not covered	Not covered
<b>Prescription Drug Coverage Network: Drug List:</b>		
<b>Day Supply Limits:</b>		
Tier 1 - Typically Generic	Not covered (retail and home delivery)	Not covered (retail and home delivery)
Tier 2 – Typically Preferred Brand	Not covered (retail and home delivery)	Not covered (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand	Not covered (retail and home delivery)	Not covered (retail and home delivery)
Tier 4 - Typically Specialty (brand and generic)	Not covered (retail and home delivery)	Not covered (retail and home delivery)

**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.
- Outpatient Facility tests and treatments are limited to \$350 per admission for Non-Network Providers. Includes: Diagnostic Services; X-ray; Surgery; Rehabilitation; Habilitation; Cardiac Therapy; Surgery at Ambulatory Surgical Centers.
- 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.
- The representations of benefits in this document are subject to California Department of Insurance (DOI) approval and are subject to change.

*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.*

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

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## Language Access Services:

### Get help in your language

Curious to know what all this says? We would be too. Here's the English version:

If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (855) 333-5730

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.

(TTY/TDD: 711)

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## Language Access Services:

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