Your summary of benefits

Anthem®

Anthem® Blue Cross

Your Plan: PRISM-San Luis Obispo County: Anthem EPO

Your Network: Prudent Buyer PPO

Covered Medical Benefits	Cost if you use an In-Network Provider
Overall Deductible	**$250 person / $750 family**
Overall Out-of-Pocket Limit	**$1,500 person / $3,000 family**
To get benefits under this Plan, you must use In-Network Providers. Services from Non-Network Providers are not covered, except for Emergency Care, Authorized Services, prescription drugs at a retail pharmacy, or when required by law. Please be sure to contact us if you are not sure if we have approved an Authorized Service. **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.** **Your copays, coinsurance and deductible count toward your out of pocket limit(s).**	
Doctor Visits (virtual and office) ***You are encouraged to select a Primary Care Physician (PCP).***	
Virtual Visits from online provider LiveHealth Online ***for urgent/acute medical and mental health and substance use disorder care via www.livehealthonline.com are covered at $10 copay per visit medical deductible does not apply.***	
Primary Care (PCP) ***virtual and office***	**$25 copay per visit medical deductible does not apply**
Mental Health and Substance Use Disorder Care ***virtual and office***	**$25 copay per visit medical deductible does not apply**
Specialist Care ***virtual and office***	**$25 copay per visit medical deductible does not apply**
Other Practitioner Visits	
Routine Maternity Care (Prenatal and Postnatal)	**0% coinsurance after medical deductible is met**
Retail Health Clinic ***for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.***	**$25 copay per visit medical deductible does not apply**
Manipulation Therapy ***Coverage is limited to 20 visits per benefit period.***	**$25 copay per visit medical deductible does not apply**

Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Covered Medical Benefits	Cost if you use an In-Network Provider
Acupuncture *Coverage is limited to 20 visits per benefit period.*	$25 copay per visit medical deductible does not apply
Other Services in an Office	
Allergy Testing	0% coinsurance after medical deductible is met
Prescription Drugs *Dispensed in the office*	0% coinsurance after medical deductible is met
Surgery	0% coinsurance after medical deductible is met
Preventive care / screenings / immunizations	No charge
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge
Diagnostic Services **Lab**	
Office	$25 copay per visit medical deductible does not apply
Freestanding Lab	$25 copay per visit medical deductible does not apply
Outpatient Hospital	$25 copay per visit medical deductible does not apply
X-Ray	
Office	$25 copay per visit medical deductible does not apply
Freestanding Radiology Center	$25 copay per visit medical deductible does not apply
Outpatient Hospital	$25 copay per visit medical deductible does not apply
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*	
Office	$25 copay per visit medical deductible does not apply
Freestanding Radiology Center	$25 copay per visit medical deductible does not apply
Outpatient Hospital	$25 copay per visit medical deductible does not apply
Emergency and Urgent Care	
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	$25 copay per visit medical deductible does not apply
Emergency Room Facility Services *Copay waived if admitted.*	In-Network and Non-Network Providers: $150 copay per visit medical deductible does not apply
Emergency Room Doctor and Other Services	In-Network and Non-Network Providers: 0% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider
Ambulance	**In-Network and Non-Network Providers:** **0% coinsurance after medical deductible is met**
<u>Outpatient Mental Health and Substance Use Disorder Care at a Facility</u>	
Facility Fees	**0% coinsurance after medical deductible is met**
Doctor Services	**0% coinsurance after medical deductible is met**
<u>Outpatient Surgery</u>	
Facility Fees	
Hospital	**0% coinsurance after medical deductible is met**
Ambulatory Surgical Center	**0% coinsurance after medical deductible is met**
Doctor and Other Services	
Hospital	**0% coinsurance after medical deductible is met**
<u>Hospital (Including Maternity, Mental Health and Substance Use Disorder)</u>	
Facility Fees	**$250 copay per admission medical deductible does not apply**
Physician and other services ***including surgeon fees***	**0% coinsurance after medical deductible is met**
Home Health Care	**0% coinsurance after medical deductible is met**
Rehabilitation and Habilitation services ***including physical, occupational and speech therapies.***	
Office	**$25 copay per visit medical deductible does not apply**
Outpatient Hospital	**$25 copay per visit medical deductible does not apply**
Pulmonary rehabilitation ***office and outpatient hospital***	**$25 copay per visit medical deductible does not apply**
Cardiac rehabilitation ***office and outpatient hospital***	**$25 copay per visit medical deductible does not apply**
Dialysis/Hemodialysis ***office and outpatient hospital***	**$25 copay per visit medical deductible does not apply**
Chemo/Radiation Therapy ***office and outpatient hospital***	**$25 copay per visit medical deductible does not apply**
Skilled Nursing Care (facility) ***Coverage is limited to 100 days per benefit period.***	**0% coinsurance after medical deductible is met**
Inpatient Hospice	**0% coinsurance after medical deductible is met**

Covered Medical Benefits	Cost if you use an In-Network Provider
Durable Medical Equipment	20% coinsurance after medical deductible is met
Prosthetic Devices	0% 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 covered	Not covered
Pharmacy Out-of-Pocket Limit	Not covered	Not covered
Prescription Drug Coverage		
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.
- 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.

Anthem

Intentionally Left Blank

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 بالرقم1-888-254-2721 (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)

Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

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 យើងអាចឲ្យនរណាម្នាក់អានវាជូនអ្នក។ អ្នកក៏អាចទទួលលិខិតនេះដោយសរសេរជាភាសារបស់អ្នកផងដែរ។ ដើម្បីទទួលជំនួយឥតគិតថ្លៃ 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 1-888-254-2721**로 전화하십시오.** (TTY/TDD: 711)

Punjabi
: ? , , 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
หมายเหตุสาคัญ: ท่านสามารถอ่านจดหมายฉบับนี้หรือไม่ หากท่านไม่สามารถอ่านจดหมายฉบับนี้ เราสามารถจัดหาเจ้าหน้าที่มาอ่านให้ท่านฟังได้ ท่านยังอาจให้เจ้าหน้าที่ช่วยเขียนจดหมายในภาษาของท่านอีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อที่มายเลข 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. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.