

# Your summary of benefits



Anthem® Blue Cross Life and Health Insurance Company

Your Plan: PRISM – CSURMA: Custom Premier PPO 150/15/30 - Medicare

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 | \$15 copay per visit medical deductible does not apply |
| Mental Health & Substance Use Disorder Services          | \$15 copay per visit medical deductible does not apply |
| Specialist care                                          | \$30 copay per visit medical deductible does not apply |

| Covered Medical Benefits    | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|-----------------------------|----------------------------------------|--------------------------------------------|
| Overall Deductible          | \$150 person                           | \$150 person                               |
| Overall Out-of-Pocket Limit | \$5,000 person                         | \$5,000 person                             |

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 Out-of-Network out-of-pocket limit amounts are combined and accumulate toward each other.

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

|                                                                                    |                                                      |                                                      |
|------------------------------------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|
| <b>Primary Care (PCP)</b> <i>virtual and office</i>                                | \$15 copay per visit after medical deductible is met | \$15 copay per visit after medical deductible is met |
| <b>Mental Health and Substance Use Disorder Services</b> <i>virtual and office</i> | No charge after medical deductible is met            | No charge after medical deductible is met            |
| <b>Specialist Provider</b> <i>virtual and office</i>                               | \$30 copay per visit after medical deductible is met | \$30 copay per visit after medical deductible is met |
| <b><u>Other Practitioner Visits</u></b>                                            |                                                      |                                                      |
| <b>Maternity services</b>                                                          |                                                      |                                                      |
| Prenatal and Postpartum care                                                       | \$15 copay per visit after medical deductible is met | \$15 copay per visit 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                                                                                                                                          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Delivery</p> <p><b>Retail Health Clinic</b> <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i></p> <p><b>Manipulation Therapy</b><br/><i>Coverage is limited to 30 visits per benefit period.</i></p> | <p>No charge after medical deductible is met</p> <p>\$15 copay per visit after medical deductible is met</p> <p>\$20 copay per visit after medical deductible is met</p>            | <p>No charge after medical deductible is met</p> <p>\$15 copay per visit after medical deductible is met</p> <p>\$20 copay per visit after medical 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> <i>Dispensed in the office</i></p> <p><b>Surgery</b></p>                                                                                                 | <p>No charge after medical deductible is met</p> <p>No charge after medical deductible is met</p> <p>No charge after medical deductible is met</p>                                  | <p>No charge after medical deductible is met</p> <p>No charge after medical deductible is met</p> <p>No charge after medical deductible is met</p>                                  |
| <b>Preventive care / screenings / immunizations</b>                                                                                                                                                                                                                  | No charge                                                                                                                                                                           | No charge                                                                                                                                                                           |
| <b>Preventive Care for Chronic Conditions</b> <i>per IRS guidelines</i>                                                                                                                                                                                              | No charge                                                                                                                                                                           | Cost share is based on the setting services are received.                                                                                                                           |
| <p><b><u>Diagnostic Services Lab</u></b></p> <p>Office</p> <p>Freestanding Lab</p> <p>Outpatient Hospital</p>                                                                                                                                                        | <p>\$30 copay per visit after medical deductible is met</p> <p>\$30 copay per visit after medical deductible is met</p> <p>\$30 copay per visit after medical deductible is met</p> | <p>\$30 copay per visit after medical deductible is met</p> <p>\$30 copay per visit after medical deductible is met</p> <p>\$30 copay per visit after medical deductible is met</p> |
| <p><b><u>Diagnostic Services X-Ray</u></b></p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>                                                                                                                                         | <p>\$30 copay per visit after medical deductible is met</p> <p>\$30 copay per visit after medical deductible is met</p> <p>\$30 copay per visit after medical deductible is met</p> | <p>\$30 copay per visit after medical deductible is met</p> <p>\$30 copay per visit after medical deductible is met</p> <p>\$30 copay per visit after medical deductible is met</p> |

| Covered Medical Benefits                                                                                                                                                                                                                                                                                                                   | Cost if you use an In-Network Provider                                                                                                                                                                                 | Cost if you use an Out-of-Network Provider                                                                                                                                   |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b><u>Diagnostic Services</u></b> <b>Advanced Diagnostic Imaging</b> <i>for example: MRI, PET and CAT scans</i><br>Office<br><br>Freestanding Radiology Center<br><br>Outpatient Hospital                                                                                                                                                  | \$75 copay per visit after medical deductible is met<br><br>\$75 copay per visit after medical deductible is met<br><br>\$75 copay per visit after medical deductible is met                                           | \$75 copay per visit after medical deductible is met<br><br>\$75 copay per visit after medical deductible is met<br><br>\$75 copay per visit after medical deductible is met |
| <b><u>Emergency and Urgent Care</u></b><br><b>Urgent Care</b> <i>includes doctor services. Additional charges may apply depending on the care provided.</i><br><br><b>Emergency Room Facility Services</b><br><i>Your copay will be waived if admitted.</i><br><br><b>Emergency Room Doctor and Other Services</b><br><br><b>Ambulance</b> | \$30 copay per visit medical deductible does not apply<br>\$75 copay per admission after medical deductible is met<br>No charge after medical deductible is met<br>\$75 copay per trip after medical deductible is met | \$30 copay per visit medical deductible does not apply<br>Covered as In-Network<br><br>Covered as In-Network<br><br>Covered as In-Network                                    |
| <b><u>Outpatient Mental Health and Substance Use Disorder Services at a Facility</u></b><br><b>Facility Fees</b><br><br><b>Doctor Services</b>                                                                                                                                                                                             | No charge after medical deductible is met<br><br>No charge after medical deductible is met                                                                                                                             | No charge after medical deductible is met<br><br>No charge after medical deductible is met                                                                                   |
| <b><u>Outpatient Surgery</u></b><br><b>Facility Fees</b><br>Hospital<br><br>Ambulatory Surgical Center<br><br><b>Physician and other services</b> <i>including surgeon fees</i><br>Hospital                                                                                                                                                | \$150 copay per visit after medical deductible is met<br><br>\$150 copay per visit after medical deductible is met<br><br>No charge after medical deductible is met                                                    | \$150 copay per visit after medical deductible is met<br><br>\$150 copay per visit after medical deductible is met<br><br>No charge 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                                                                               |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|
| <b><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u></b><br><br><b>Facility Fees</b><br><br><b>Physician and other services</b> <i>including surgeon fees</i> | <br><br>\$500 copay per admission after medical deductible is met<br><br>No charge after medical deductible is met       | <br><br>\$500 copay per admission after medical deductible is met<br><br>No charge after medical deductible is met       |
| <b><u>Home Health Care</u></b><br><i>Coverage is limited to 100 visits per benefit period.</i>                                                                                                       | No charge                                                                                                                | No charge                                                                                                                |
| <b><u>Therapy Services</u></b><br><b>Rehabilitation and Habilitation services</b> <i>including physical, occupational and speech therapies.</i><br><br>Office<br><br>Outpatient Hospital             | <br><br>\$30 copay per visit after medical deductible is met<br><br>\$30 copay per visit after medical deductible is met | <br><br>\$30 copay per visit after medical deductible is met<br><br>\$30 copay per visit after medical deductible is met |
| <b>Pulmonary rehabilitation</b> <i>office and outpatient hospital</i>                                                                                                                                | \$30 copay per visit after medical deductible is met                                                                     | \$30 copay per visit after medical deductible is met                                                                     |
| <b>Cardiac rehabilitation</b> <i>office and outpatient hospital</i>                                                                                                                                  | \$30 copay per visit after medical deductible is met                                                                     | \$30 copay per visit after medical deductible is met                                                                     |
| <b>Dialysis/Hemodialysis</b> <i>office and outpatient hospital</i>                                                                                                                                   | No charge after medical deductible is met                                                                                | No charge after medical deductible is met                                                                                |
| <b>Chemo/Radiation Therapy</b> <i>office and outpatient hospital</i>                                                                                                                                 | No charge after medical deductible is met                                                                                | No charge after medical deductible is met                                                                                |
| <b>Skilled Nursing Care (facility)</b><br><i>Coverage is limited to 100 days per benefit period.</i>                                                                                                 | No charge after medical deductible is met                                                                                | No charge after medical deductible is met                                                                                |
| <b>Inpatient Hospice</b>                                                                                                                                                                             | No charge                                                                                                                | No charge                                                                                                                |
| <b><u>Additional Services, Equipment and Devices</u></b><br><b>Durable Medical Equipment</b>                                                                                                         | No charge after medical deductible is met                                                                                | No charge 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      |
|--------------------------|-------------------------------------------------|-------------------------------------------------|
| Prosthetic Devices       | 10% coinsurance after medical deductible is met | 10% coinsurance after medical 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 covered                            | Not covered                                |
| Pharmacy Out-of-Pocket Limit                                              | Not covered                            | Not covered                                |
| <b>Prescription Drug Coverage</b><br><b>Network:</b><br><b>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 visit for Mental/Behavioral Health and Substance Abuse is limited to \$350 per visit 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.*

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

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-888-254-2721. For more help call the CA Dept. of Insurance at 1-800-927-4357 (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternative 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

Servicios lingüísticos sin costo. Puede solicitar los servicios de un intérprete. También puede solicitar que le leamos y le enviemos algunos documentos en su idioma. Llame al número que figura en su tarjeta de identificación o al 1-888-254-2721. Si necesita más ayuda, llame al Departamento de Seguros de California al 1-800-927-4357 (TTY/TDD: 711).

#### Arabic

خدمات لغوية مجانية. يمكنك الحصول على مترجم فوري. يمكنك الحصول على مستندات تُقرأ لك وإرسال بعضها إليك بلغتك. للحصول على المساعدة، اتصل بنا على الرقم المدرج على بطاقة الهوية الخاصة بك أو 1-800-254-2721. لمزيد من المساعدة اتصل بقسم التأمين في CA على الرقم 1-800-927-4357 (TTY/TDD: 711)

#### Armenian

Առանց արժեքի լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Դուք կարող եք ստանալ փաստաթղթեր, որոնք կարդում են ձեզ համար, իսկ որոշները՝ ուղարկվում են ձեր լեզվով: Օգնության համար զանգահարեք մեզ ձեր ID քարտում նշված համարով կամ 1-888-254-2721 հեռախոսահամարով: Լրացուցիչ օգնության համար զանգահարեք CA Ապահովագրության բաժանմունք՝ 1-800-927-4357 (TTY/TDD: 711)

#### Chinese

免費語言服務。您可獲得口譯員服務。可以把文件唸給您聽，有些文件有您的語言的版本，也可以把這些文件寄給您。欲取得協助，請致電您的ID卡所列的電話號碼，或致電 1-888-254-2721 與我們聯絡。欲取得其他協助，請致電 1-800-927-4357 (TTY/TDD: 711) 與 CA 保險部聯絡

#### Farsi

خدمات زبان بدون هزینه. شما می‌توانید مترجم شفاهی درخواست کنید. می‌توانید بخواهید اسناد برای شما به زبان شما خوانده شود و برخی اسناد به زبان شما برایتان ارسال شود. برای راهنمایی، با ما با شماره مندرج در کارت عضویت خود یا شماره 1-888-254-2721 تماس بگیرید. برای راهنمایی بیشتر با بخش بیمه CA به شماره 1-800-927-4357 (TTY/TDD: 711) تماس بگیرید.

#### Hindi

निःशुल्क भाषा सेवाएँ। आप एक दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेज़ अपनी भाषा में पढ़वा सकते हैं और कुछ को अपनी भाषा में खुद तक भिजवा सकते हैं। सहायता के लिए, अपने आईडी कार्ड पर दिए गए नंबर पर या 1-888-254-2721 पर हमें कॉल करें। अधिक सहायता के लिए सीए बीमा विभाग को 1-800-927-4357 पर कॉल करें (TTY/TDD: 711)

#### Hmong

Tsis Sau Nqi Rau Kev Pab Cuam Txog Lus. Koj tuaj yeem tau txais tus kws txhais lus. Koj tuaj yeem tau txais cov ntaub ntawv kom muab nyeem rau koj mloog thiab kom muab xa rau koj ua yam lus koj hais. Rau kev pab, hu peb tus npawb xov tooj muaj nyob ntawm koj daim npav ID los sis 1-888-254-2721. Rau kev pab ntxiv hu lub CA Tuam Tsev Hauj Lwm ntsig txog Kev Tuav Pov Hwm ntawm 1-800-927-4357 (TTY/TDD: 711)

#### Japanese

無料の言語サービス。通訳を頼むこともできます。文書を使用言語で読み上げたり、送信したりすることもできます。サポートが必要な場合、IDカードに記載されている電話番号または 1-888-254-2721 までお電話ください。さらに詳しい情報については、カリフォルニア州保険局までお問い合わせください。電話番号：1-800-927-4357 (TTY/TDD: 711)

**Khmner**

មិនគិតថ្លៃសេវាកម្មទេ។ អ្នកអាចទទួលបានអ្នកបកប្រែ។ អ្នកអាចទទួលបានឯកសារអានឱ្យអ្នកស្តាប់ និងឯកសារខ្លះផ្សេងទៀតអ្នកជាភាសាបស្ចិម។ សម្រាប់ជំនួយ សូមទូរសព្ទមកយើងតាមលេខដែលមាននៅក្នុងកាត ID របស់អ្នក ឬ 1-888-254-2721។ សម្រាប់ជំនួយបន្ថែម សូមទូរសព្ទទៅផ្នែកធានារ៉ាប់រង CA តាមរយៈលេខ 1-800-927-4357 (TTY/TDD: 711)

**Korean**

무상 언어 서비스. 통역사를 연결시켜 드립니다. 문서를 귀하에게 읽어드릴 수 있고 어떤 서류는 귀하의 언어로 작성하여 맥으로 보내드릴 수 있습니다. 도움이 필요하시면, 귀하의 ID 카드에 나와 있는 번호 또는 1-888-254-2721 번으로 전화해 주시기 바랍니다. 더 많은 도움이 필요하시면 CA 보험부에 1-800-927-4357 (TTY/TDD: 711)로 전화해 주십시오.

**Punjabi**

ਬਿਨਾਂ ਕੋਈ ਲਾਗਤ ਤਾਮਾ ਸੇਵਾਵਾਂ ਤੁਸੀਂ ਦੁਆਰਾ ਲੈ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੜ੍ਹ ਕੇ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਕੁਝ ਤੁਹਾਡੀ ਤਾਮਾ ਵਿੱਚ ਤੁਹਾਨੂੰ ਭੇਜੇ ਗਏ ਹਨ। ਮਦਦ ਲਈ, ਸਾਨੂੰ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਸੂਚੀਬੱਧ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ 1-888-254-2721. ਹੋਰ ਮਦਦ ਲਈ CA ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ ਇੱਥੇ ਕਾਲ ਕਰੋ 1-800-927-4357 (TTY/TDD: 711)

**Russian**

Доступны бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика. Вам могут зачитать документы вслух, а некоторые из них могут быть отправлены вам на вашем языке. Если вам нужна помощь, позвоните нам по номеру, указанному на вашей идентификационной карте участника плана, или по номеру 1-888-254-2721. Для получения дополнительной помощи позвоните в Департамент страхования штата California по номеру 1-800-927-4357 (TTY/TDD: 711)

**Tagalog**

Walang Gastos na mga Serbisyo sa Wika. Maaari kang kumuha ng interpreter. Maaari mong ipabasa ang mga dokumento sa iyo at ipadala sa iyo ang ilan sa nang nasa wika mo. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card o 1-888-254-2721. Para sa higit pang tulong tumawag sa CA Dept. of Insurance sa 1-800-927-4357 (TTY/TDD: 711)

**Thai**

บริการด้านภาษาแบบไม่เสียค่าใช้จ่าย คุณสามารถรับล่ามเพื่อช่วยเหลือได้ คุณสามารถรับเอกสารแบบมีผู้อ่านให้ฟังและส่งให้คุณในภาษาของคุณได้ หากต้องการความช่วยเหลือ โปรดโทรติดต่อเราตามหมายเลขที่ระบุบนบัตรประจำตัวของคุณหรือ 1-888-254-2721 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรติดต่อกรมการประกันภัยแห่งแคลิฟอร์เนียได้ที่ 1-800-927-4357 (TTY/TDD: 711)

**Vietnamese**

Dịch vụ Ngôn ngữ Miễn Phí. Quý vị có thể được bố trí thông dịch viên. Quý vị có thể yêu cầu họ đọc tài liệu hoặc gửi cho quý vị một số tài liệu bằng ngôn ngữ của quý vị. Để được trợ giúp, hãy gọi cho chúng tôi theo số điện thoại được ghi trên thẻ ID của quý vị hoặc 1-888-254-2721. Để được trợ giúp thêm, hãy gọi cho Sở Bảo hiểm CA theo số 1-800-927-4357 (TTY/TDD: 711)

**It's important we treat you fairly**

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