# Your summary of benefits

Anthem

Anthem® Blue Cross Life and Health Insurance Company

Your Plan: PACE: Modified Classic PPO 300/20/10

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 medical deductible does not apply |
| **Mental Health & Substance Use Disorder Services** | No charge medical deductible does not apply |
| **Specialist care** | $20 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** | $300 person / $900 family | $600 person / $1,800 family |
| **Overall Out-of-Pocket Limit** | $3,000 person / $6,000 family | $3,000 person / $6,000 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.<br>All medical deductibles, copayments and coinsurance apply to the out-of-pocket limit.<br>In-Network and Out-of-Network deductibles are separate and do not accumulate toward each other; however, 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).* | | |
| **Primary Care (PCP)** *virtual and office* | $20 copay per visit medical deductible does not apply | 10% coinsurance after medical deductible is met |
| **Mental Health and Substance Use Disorder Services** *virtual and office* | $20 copay per visit medical deductible does not apply | 10% coinsurance after medical deductible is met |
| **Specialist Provider** *virtual and office* | $20 copay per visit medical deductible does not apply | 10% coinsurance after medical deductible is met |
| **Other Practitioner Visits** | | |
| **Maternity Doctor services** (prenatal/postpartum care and delivery) | 10% coinsurance after medical deductible is met | 10% coinsurance 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 |
|---|---|---|
| **Retail Health Clinic** *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.* | $20 copay per visit medical deductible does not apply | 10% coinsurance after medical deductible is met |
| **Manipulation Therapy**<br>*Coverage is limited to 20 visits per benefit period.* | $20 copay per visit medical deductible does not apply | 10% coinsurance after medical deductible is met |
| **Acupuncture** | $20 copay per visit medical deductible does not apply | 10% coinsurance after medical deductible is met |
| **Other Services in an Office** | | |
| **Allergy Testing** | 10% coinsurance after medical deductible is met | 10% coinsurance after medical deductible is met |
| **Prescription Drugs** *Dispensed in the office*<br>*Maximum of $250 member cost share per drug.* | 10% coinsurance after medical deductible is met | 10% coinsurance after medical deductible is met |
| **Surgery** | 10% coinsurance after medical deductible is met | 10% coinsurance after medical deductible is met |
| **Preventive care / screenings / immunizations** | No charge | No charge |
| **Preventive Care for Chronic Conditions** *per IRS guidelines* | No charge | Cost share is based on the setting services are received. |
| **Diagnostic Services Lab** | | |
| Office | 10% coinsurance after medical deductible is met | 10% coinsurance after medical deductible is met |
| Freestanding Lab | 10% coinsurance after medical deductible is met | 10% coinsurance after medical deductible is met |
| Outpatient Hospital | 10% coinsurance after medical deductible is met | 10% coinsurance after medical deductible is met |
| **Diagnostic Services X-Ray** | | |
| Office | 10% coinsurance after medical deductible is met | 10% coinsurance after medical deductible is met |
| Freestanding Radiology Center | 10% coinsurance after medical deductible is met | 10% coinsurance after medical deductible is met |
| Outpatient Hospital | 10% coinsurance after medical deductible is met | 10% coinsurance 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 |
|---|---|---|
| **Diagnostic Services Advanced Diagnostic Imaging** *for example: MRI, PET and CAT scans* | | |
| Office | 10% coinsurance after medical deductible is met | 10% coinsurance after medical deductible is met |
| Freestanding Radiology Center | 10% coinsurance after medical deductible is met | 10% coinsurance after medical deductible is met |
| Outpatient Hospital | 10% coinsurance after medical deductible is met | 10% coinsurance after medical deductible is met |
| **Emergency and Urgent Care** | | |
| **Urgent Care** *includes doctor services. Additional charges may apply depending on the care provided.* | $20 copay per visit medical deductible does not apply | 10% coinsurance after medical deductible is met |
| **Emergency Room Facility Services** | 10% coinsurance after medical deductible is met | Covered as In-Network |
| **Emergency Room Doctor and Other Services** | 10% coinsurance after medical deductible is met | Covered as In-Network |
| **Ambulance** | 20% coinsurance after medical deductible is met | Covered as In-Network |
| **Outpatient Mental Health and Substance Use Disorder Services at a Facility** | | |
| **Facility Fees** | 10% coinsurance after medical deductible is met | 10% coinsurance after medical deductible is met |
| **Doctor Services** | 10% coinsurance after medical deductible is met | 10% coinsurance after medical deductible is met |
| **Outpatient Surgery** | | |
| **Facility Fees** | | |
| Hospital | 10% coinsurance after medical deductible is met | 10% coinsurance after medical deductible is met |
| Ambulatory Surgical Center | 10% coinsurance after medical deductible is met | 10% coinsurance 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 |
|---|---|---|
| **Physician and other services** *including surgeon fees* | | |
| Hospital | 10% coinsurance after medical deductible is met | 10% coinsurance after medical deductible is met |
| **Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)** | | |
| **Facility Fees** | 10% coinsurance after medical deductible is met | 10% coinsurance after medical deductible is met |
| **Physician and other services** *including surgeon fees* | 10% coinsurance after medical deductible is met | 10% coinsurance after medical deductible is met |
| **Home Health Care**<br>*Coverage is limited to 100 visits per benefit period.* | 10% coinsurance after medical deductible is met | 10% coinsurance after medical deductible is met |
| **Therapy Services** | | |
| **Rehabilitation and Habilitation services** *including physical, occupational and speech therapies.* | | |
| Office | 10% coinsurance after medical deductible is met | 10% coinsurance after medical deductible is met |
| Outpatient Hospital | 10% coinsurance after medical deductible is met | 10% coinsurance after medical deductible is met |
| **Pulmonary rehabilitation** *office and outpatient hospital* | 10% coinsurance after medical deductible is met | 10% coinsurance after medical deductible is met |
| **Cardiac rehabilitation** *office and outpatient hospital* | 10% coinsurance after medical deductible is met | 10% coinsurance after medical deductible is met |
| **Dialysis/Hemodialysis** | | |
| Office | 10% coinsurance medical deductible does not apply | 10% coinsurance medical deductible does not apply |
| Outpatient Hospital | 10% coinsurance after medical deductible is met | 10% coinsurance after medical deductible is met |
| **Chemo/Radiation Therapy** | | |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|
| Office | 10% coinsurance medical deductible does not apply | 10% coinsurance medical deductible does not apply |
| Outpatient Hospital | 10% coinsurance after medical deductible is met | 10% coinsurance after medical deductible is met |
| **Skilled Nursing Care (facility)**<br>*Coverage is limited to 100 days per benefit period.* | 10% coinsurance after medical deductible is met | 10% coinsurance after medical deductible is met |
| **Inpatient Hospice** | 10% coinsurance after medical deductible is met | 10% coinsurance after medical deductible is met |
| **Additional Services, Equipment and Devices** | | |
| **Durable Medical Equipment** | 20% coinsurance after medical deductible is met | 20% coinsurance after medical deductible is met |
| **Prosthetic Devices** | 20% coinsurance after medical deductible is met | 20% coinsurance after medical deductible is met |
| **Wigs**<br>*Coverage for wigs is limited to 1 item after cancer treatment per benefit period.* | 20% coinsurance after medical deductible is met | 20% coinsurance after medical deductible is met |
| **Hearing Aids**<br>*Coverage is limited to 1 item(s) per ear every 36 months.* | 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 |
| **Prescription Drug Coverage**<br>**Network:**<br>**Drug List:** | | |
| **Day Supply Limits:** | | |
| **Tier 1 - Typically Generic** | Not covered (retail and home delivery) | Not covered (retail and home delivery) |

| Covered Prescription Drug Benefits | Cost if you use an In-Network Pharmacy | Cost if you use an Out-of-Network Pharmacy |
|---|---|---|
| **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 Out-of-Network Providers. Includes: Diagnostic Services; X-ray; Surgery; Rehabilitation; Habilitation; Cardiac Therapy; Surgery at Ambulatory Surgical Centers; Allergy Testing.
- Advanced Diagnostic Imaging is limited to $800 per service for Out-of-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

Anthem

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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:*
*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 with translations or interpreter services, in a timely manner, please call the telephone number on the back of your ID card. (TTY/TDD: 711). 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**

*IMPORTANTE: ¿Puede leer esta carta? Si no puede leerla, podemos hacer que alguien lo ayude a leerla. También es posible que pueda recibir esta carta escrita en su idioma.*
*Para obtener ayuda gratuita con traducciones o servicios de interpretación, de manera oportuna, llame al número de teléfono que figura en el dorso de su tarjeta de identificación. (TTY/TDD: 711). Para obtener más ayuda llame al Departamento de Seguros de California al 1-800-927-4357 (TTY/TDD: 711)*

**Arabic**

*هام: هل يمكنك قراءة هذا الخطاب؟ إذا كان لا يمكنك ذلك، يمكننا أن نوفر لك شخصًا ما ليساعدك على قراءته. يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية بشأن الترجمات المكتوبة والفورية، وفي الوقت المناسب، يُرجى الاتصال برقم الهاتف المكتوب على ظهر بطاقة ID الخاصة بك.*
*(TTY/TDD: 711). للحصول على المزيد من المساعدة اتصل على إدارة التأمين في CA على الرقم 1-800-927-4357 (TTY/TDD: 711)*

**Armenian**

*նամակը: Եթե ոչ, մեր մասնագետներից մեկը կարող է օգնել ձեզ կարդալ այն: Դուք կարող եք նաև այս նամակը ստանալ ձեր լեզվով: Թարգմանությունների կամ թարգմանչական ծառայությունների անվճար և ժամանակին օգնության համար խնդրում ենք զանգահարել ձեր ID քարտի հակառակ կողմում նշված հեռախոսահամարով: (TTY/TDD՝ 711): Ավելի շատ օգնության համար զանգահարեք CA-ի ապահովագրության բաժին՝ 1-800-927-4357 հեռախոսահամարով (TTY/TDD՝ 711):*

**Chinese**

*重要提示：您能看此信嗎？如果不能，我們可以請人幫您看。您還可以獲得以您的語言寫的此信件。如需及時獲得免費的翻譯或口譯服務協助，請撥打您 ID 卡背面的電話號碼。(TTY/TDD: 711)。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**

*مهم: آیا می‌توانید این نامه را بخوانید؟ اگر نمی‌توانید، می‌توانیم ترتیبی دهیم که کسی در خواندن آن به شما کمک کند. همچنین ممکن است بتوانید این نامه را به‌صورت کتبی به زبان خودتان دریافت کنید. برای کمک رایگان و به‌موقع در خدمات ترجمه کتبی و شفاهی، لطفاً با شماره تلفن مندرج در پشت کارت ID خود تماس بگیرید. (TTY/TDD: 711) برای دریافت کمک بیشتر، با اداره بیمه CA به شماره 1-800-927-4357 تماس بگیرید (TTY/TDD: 711)*

**Hindi**

*महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम किसी से इसे पढ़ने में आपकी मदद करवा सकते हैं। आप इस पत्र को अपनी भाषा में भी लिखवा सकते हैं। अनुवाद या द्विभाषिया सेवाओं में मुफ़्त मदद के लिए, कृपया समय पर अपने पहचान पत्र के पीछे दिए गए फ़ोन नंबर पर कॉल करें। (TTY/TDD: 711) । अधिक सहायता के लिए कैलिफ़ोर्निया बीमा विभाग को CA 1-800-927-4357 (TTY/TDD: 711) पर कॉल करें।*

**Hmong**

*TSEEM CEEB: Koj nyeem puas tau tsab ntawv no? Yog nyeem tsis tau, peb muaj neeg los pab koj nyeem nws. Koj los yeej tuaj yeem tau txais daim ntawv no ua koj yam lus. Kom tau txais kev pab txhais ntaub ntawv los sis cov kev pab cuam txhais lus pab dawb, kom raws sij hawm, thov hu tus npawb xov tooj nyob sab nraum qab ntawm koj daim npawv ID. (TTY/TDD: 711). Rau kev pab ntxiv hu lub CA Lub Tuam Tsev Hauj Lwm ntsig txog Kev Tuav Pov Hwm ntawm 1-800-927-4357 (TTY/TDD: 711)*

**Japanese**
*重要：この手紙を読むことができますか？もし読めない場合は、読むのを手伝ってもらうことができます。 また、この手紙をお使いの言語で入手できる場合もあります。翻訳や通訳サービスの無料サポートが必要な場合は、お持ちの ID カード裏面に記載されている電話番号まで、できるだけ早くお電話ください。（TTY/TDD: 711）さらに詳しいサポートが必要な場合は、CA カリフォルニア州保険局までご連絡ください。電話番号：1-800-927-4357（TTY/TDD: 711）*

**Khmer**
*ចំណុចសំខាន់៖ តើអ្នកអាចអានសំបុត្រនេះដែរឬទេ? ប្រសិនបើមិនទេនោះ យើងអាចឱ្យអ្នកណាម្នាក់ជួយអ្នកអានវាបាន។ អ្នកក៏អាចឱ្យគេសរសេរសំបុត្រនេះជាភាសារបស់អ្នកបានផងដែរ។ សម្រាប់ជំនួយឥតគិតថ្លៃជាមួយនឹងសេវាបកប្រែឯកសារ ឬផ្ទាល់មាត់ឱ្យបានទាន់ពេលវេលា សូមទូរស័ព្ទទៅកាន់លេខនៅផ្នែកខាងក្រោយកាត ID សម្គាល់របស់អ្នក។ (TTY/TDD: 711)។ សម្រាប់ជំនួយបន្ថែម សូមទូរស័ព្ទទៅកាន់ក្រសួងធានាភ័ស្តុងនៃរដ្ឋ CA តាមលេខ 1-800-927-4357 (TTY/TDD: 711)*

**Korean**
*중요: 이 서신을 읽으실 수 있습니까? 그렇지 않다면 서신을 읽을 수 있게 도움을 드릴 수 있습니다. 원하시는 언어로 이 서신을 받으실 수도 있습니다. 번역이나 통역 서비스를 무료로 즉시에 이용하시려면 ID 카드 뒷면에 있는 전화번호로 전화해 주십시오. (TTY/TDD: 711). 추가 도움이 필요하시면 CA 보험부에 1-800-927-4357 (TTY/TDD: 711)번으로 전화해 주십시오.*

**Punjabi**
*ਮਹੱਤਵਪੂਰਨ ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵੀ ਲਿਖਵਾ ਸਕਦੇ ਹੋ। ਅਨੁਵਾਦ ਜਾਂ ਦੁਭਾਸ਼ੀਏ ਸੇਵਾਵਾਂ ਵਿੱਚ ਮੁਫ਼ਤ ਮਦਦ ਲਈ, ਸਮੇਂ ਸਿਰ, ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੇ ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਟੈਲੀਫੋਨ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711). ਹੋਰ ਮਦਦ ਲਈ CA ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ 1-800-927-4357 (TTY/TDD: 711) 'ਤੇ ਕਾਲ ਕਰੋ।*

**Russian**
*ВАЖНАЯ ИНФОРМАЦИЯ: Можете ли вы прочитать данное письмо? Если нет, наш сотрудник поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Чтобы своевременно получить бесплатные услуги письменного или устного перевода, позвоните по номеру телефона, указанному на оборотной стороне вашей идентификационной карты участника (TTY/TDD: 711). Для получения дополнительной помощи позвоните в Департамент страхования штата CA по номеру 1-800-927-4357 (TTY/TDD: 711)*

**Tagalog**
*MAHALAGA: Puwede mo bang basahin ang sulat na ito? Kung hindi, puwede tayong humanap ng taong tutulong sa iyo na basahin ito. Maaaring matanggap mo rin ang sulat na ito sa iyong wika. Para sa libreng tulong sa pagsasalin-wika o mga serbisyo ng interpreter, na napapanahon, mangyaring tawagan ang numero ng telepono sa likod ng iyong card ng ID. (TTY/TDD: 711). Para sa higit pang tulong tawagan ang Departamentol ng Insurance ng CA sa 1-800-927-4357 (TTY/TDD: 711)*

**Thai**
*ข้อสำคัญ: คุณอ่านจดหมายนี้ได้หรือไม่ หากไม่ได้ เรามีคนช่วยอ่านให้คุณหรือสามารถขอให้ส่งจดหมายนี้เป็นภาษาที่คุณต้องการ ขอความช่วยเหลือด้านการแปลหรือบริการล่ามที่รวดเร็วโดยติดต่อหมายเลขโทรศัพท์ที่ด้านหลังบัตรประจำตัวของคุณ (TTY/TDD: 711).*
*ขอความช่วยเหลือเพิ่มเติมโดยติดต่อ CA ฝ่ายประกันภัยที่หมายเลข 1-800-927-4357 (TTY/TDD: 711).*

**Vietnamese**
*QUAN TRỌNG: Quý vị có thể đọc được lá thư này không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc. Quý vị cũng có thể yêu cầu nhận lá thư này được viết bằng ngôn ngữ của quý vị. Để được hỗ trợ miễn phí về dịch vụ biên dịch hoặc thông dịch, vui lòng gọi số điện thoại ở mặt sau thẻ ID của quý vị để được hỗ trợ kịp thời. (TTY/TDD: 711). Để được giúp đỡ thêm, hãy gọi Sở Bảo hiểm CA theo số 1-800-927-4357 (TTY/TDD: 711).*

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