

Your summary of benefits



Anthem® Blue Cross

Your Plan: PRISM (County of Tehama) Anthem EPO 500/15/10

Your Network: Prudent Buyer PPO

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$500 person / \$1,500 family	Not covered
Out-of-Pocket Limit	\$3,000 person / \$9,000 family	Not covered
<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>		
Preventive Care / Screening / Immunization	No charge	Not covered
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	Not covered
<p><u>Virtual Care (Telemedicine / Telehealth Visits)</u></p> <p>Virtual Visits - Online visits with Doctors who also provide services in person</p>		
Primary Care (PCP)	\$15 copay per visit deductible does not apply	Not covered
Mental Health and Substance Use Disorder care	\$15 copay per visit deductible does not apply	Not covered
Specialist	\$15 copay per visit deductible does not apply	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Virtual Visits from Online Provider LiveHealth Online via www.livehealthonline.com; 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>No charge</p> <p>\$15 copay per visit deductible does not apply</p>	<p>Not covered</p> <p>Not covered</p>
<p><u>Visits in an Office</u></p> <p>Primary Care (PCP)</p> <p>Specialist Care</p>	<p>\$15 copay per visit deductible does not apply</p> <p>\$15 copay per visit deductible does not apply</p>	<p>Not covered</p> <p>Not covered</p>
<p><u>Other Practitioner Visits</u></p> <p>Routine Maternity Care (Prenatal and Postnatal)</p> <p>Retail Health Clinic</p> <p>Manipulation Therapy <i>Coverage is limited to 24 visits per benefit period. Limit is combined with Physical Therapy and Occupational Therapy.</i></p> <p>Acupuncture <i>Coverage is limited to 12 visits per benefit period.</i></p>	<p>\$15 copay per visit deductible does not apply</p> <p>\$15 copay per visit deductible does not apply</p> <p>10% coinsurance after the deductible is met</p> <p>10% coinsurance after the deductible is met</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><u>Other Services in an Office</u></p> <p>Allergy Testing</p> <p>Chemo/Radiation Therapy</p> <p>Dialysis/Hemodialysis</p> <p>Prescription Drugs <i>Dispensed in the office</i></p>	<p>10% coinsurance after the deductible is met</p> <p>10% coinsurance after the deductible is met</p> <p>10% coinsurance after the deductible is met</p> <p>10% coinsurance after the deductible is met</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p> <p>Not covered</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Surgery	10% coinsurance after the deductible is met	Not covered
<u>Diagnostic Services</u> Lab Office Freestanding Lab Outpatient Hospital	 10% coinsurance after the deductible is met 10% coinsurance after the deductible is met 10% coinsurance after the deductible is met	 Not covered Not covered Not covered
X-Ray Office Freestanding Radiology Center Outpatient Hospital	 10% coinsurance after the deductible is met 10% coinsurance after the deductible is met 10% coinsurance after the deductible is met	 Not covered Not covered Not covered
Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i> Office Freestanding Radiology Center Outpatient Hospital	 10% coinsurance after the deductible is met 10% coinsurance after the deductible is met 10% coinsurance after the deductible is met	 Not covered Not covered Not covered
<u>Emergency and Urgent Care</u> Urgent Care Emergency Room Facility Services <i>Copay waived if admitted.</i> Emergency Room Doctor and Other Services	 \$15 copay per visit deductible does not apply \$100 copay per visit and then 10% coinsurance after deductible is met 10% coinsurance after the deductible is met	 Not covered 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
Ambulance	10% coinsurance after the deductible is met	Covered as In-Network
<u>Outpatient Mental Health and Substance Use Disorder</u> Doctor Office Visit Facility Visit Facility Fees Doctor Services	\$15 copay per visit deductible does not apply 10% coinsurance after the deductible is met 10% coinsurance after the deductible is met	Not covered Not covered Not covered
<u>Outpatient Surgery</u> Facility Fees Hospital Freestanding Surgical Center Doctor and Other Services Hospital	10% coinsurance after the deductible is met 10% coinsurance after the deductible is met 10% coinsurance after the deductible is met	Not covered Not covered Not covered
<u>Hospital (Including Maternity, Mental Health and Substance Use Disorder)</u> Facility Fees Doctor and other services	10% coinsurance after the deductible is met 10% coinsurance after the deductible is met	Not covered Not covered
<u>Recovery & Rehabilitation</u> Home Health Care <i>Coverage is limited to 100 visits per benefit period.</i>	10% coinsurance after the deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Rehabilitation services <i>Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 24 visits per benefit period. Limit is combined with Manipulation Therapy.</i>		
Office	10% coinsurance after the deductible is met	Not covered
Outpatient Hospital	10% coinsurance after the deductible is met	Not covered
Cardiac rehabilitation		
Office	10% coinsurance after the deductible is met	Not covered
Outpatient Hospital	10% coinsurance after the deductible is met	Not covered
Skilled Nursing Care (facility) <i>Coverage is limited to 100 days per benefit period.</i>	10% coinsurance after the deductible is met	Not covered
Inpatient Hospice	10% coinsurance after the deductible is met	Not covered
Durable Medical Equipment	10% coinsurance after the deductible is met	Not covered
Prosthetic Devices	10% coinsurance after the deductible is met	Not covered

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.
- 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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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

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

ՌԻՇՄԱՐՈՒԹՅՈՒՆ. 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 անհատապես 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៖ តើអ្នកអាចអានប៊ិចតេនេះ? បើមិនអាចទេ យើងអាចផ្តល់ការបកប្រែសំខាន់ៗឱ្យអ្នកបាន។ អ្នកក៏អាចទទួលបានប៊ិចតេនេះភាសាសំខាន់ៗផ្សេងទៀតដែរ។ តើអ្នកចង់ទទួលបានជំនួយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗតាមលេខ 1-888-254-2721, (TTY/TDD: 711)

Korean
: ? 가
1-888-254-2721 (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
หมายเหตุสำคัญ: ท่านสามารถอ่านจดหมายฉบับนี้หรือไม่ หากท่านไม่สามารถอ่านจดหมายฉบับนี้ เราสามารถจัดหาเจ้าหน้าที่มาอ่านให้ท่านฟังได้ ท่านยังสามารถให้เจ้าหน้าที่ที่ช่วยเขียนจดหมายในภาษาของท่านอีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อทันที หมายเลข 1-888-254-2721 (T

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
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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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