

# Your summary of benefits



Anthem Blue Cross Life and Health Insurance Company

Your Plan: PRISM (CSURMA): Custom Premier PPO 500/20/90/60

Your Network: Prudent Buyer PPO

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b>	\$500 person / \$1,000 family	\$500 person / \$1,000 family
<b>Out-of-Pocket Limit</b>	\$2,500 person / \$5,000 family	\$2,500 person / \$5,000 family
<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> <p>In-network and out-of-network deductibles are combined and accumulate toward each other; in-network and out-of-network out-of-pocket maximum amounts are combined and accumulate toward each other.</p>		
<b>Preventive Care / Screening / Immunization</b>	No charge	40% coinsurance after deductible is met
<b>Preventive Care for Chronic Conditions</b> <i>per IRS guidelines</i>	No charge	40% coinsurance after deductible is met
<p><b><u>Virtual Care (Telemedicine / Telehealth Visits)</u></b></p> <p><b>Virtual Visits - Online visits with Doctors who also provide services in person</b></p> <p>Primary Care (PCP) ) including Mental Health and Substance Abuse care by a PCP</p> <p>Mental Health and Substance care by Providers other than a PCP</p> <p>Specialist</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>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% 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>Virtual Visits from Online Provider LiveHealth Online</b> via <a href="http://www.livehealthonline.com">www.livehealthonline.com</a>; 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>\$10 copay per visit deductible does not apply</p> <p>\$20 copay per visit deductible does not apply</p>	
<p><b><u>Visits in an Office</u></b></p> <p><b>Primary Care (PCP)</b></p> <p><b>Specialist Care</b></p>	<p>\$20 copay per visit deductible does not apply</p> <p>\$20 copay per visit deductible does not apply</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<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></p> <p><b>Manipulation Therapy</b> <i>Coverage is limited to 30 visits per benefit period.</i></p> <p><b>Acupuncture</b> <i>Coverage is limited to 20 visits per benefit period.</i></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>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% 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>Chemo/Radiation Therapy</b></p> <p><b>Dialysis/Hemodialysis</b></p> <p><b>Prescription Drugs</b> <i>Dispensed in the office</i></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>10% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% 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
<b>Surgery</b>	10% coinsurance after deductible is met	40% coinsurance after deductible is met
<b><u>Diagnostic Services</u></b> <b>Lab</b> Office Freestanding Lab Outpatient Hospital	 10% coinsurance after deductible is met 10% coinsurance after deductible is met 10% coinsurance after deductible is met	 40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met
<b>X-Ray</b> Office Freestanding Radiology Center Outpatient Hospital	 10% coinsurance after deductible is met 10% coinsurance after deductible is met 10% coinsurance after deductible is met	 40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met
<b>Advanced Diagnostic Imaging</b> <i>for example: MRI, PET and CAT scans</i> Office Freestanding Radiology Center Outpatient Hospital	 10% coinsurance after deductible is met 10% coinsurance after deductible is met 10% coinsurance after deductible is met	 40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met
<b><u>Emergency and Urgent Care</u></b> <b>Urgent Care</b>  <b>Emergency Room Facility Services</b> <i>Copay waived if admitted.</i>  <b>Emergency Room Doctor and Other Services</b>  <b>Ambulance</b>	 \$20 copay per visit deductible does not apply  \$50 copay per visit and then 10% coinsurance after deductible is met  10% coinsurance after deductible is met  10% coinsurance after deductible is met	 40% coinsurance after deductible is met  Covered as In-Network  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
<p><b><u>Outpatient Mental Health and Substance Use Disorder</u></b></p> <p><b>Doctor Office Visit</b></p> <p><b>Facility Visit</b></p> <p>Facility Fees</p> <p>Doctor Services</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>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b><u>Outpatient Surgery</u></b></p> <p><b>Facility Fees</b></p> <p>Hospital</p> <p>Freestanding Surgical Center</p> <p><b>Doctor and Other Services</b></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>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder)</u></b></p> <p><i>Member is responsible for an additional \$500 copay if prior authorization is not obtained from Anthem for non-emergency Inpatient admissions to non-network providers. Anthem's maximum payment is up to \$600 per day for non-emergency Inpatient admissions to non-network providers.</i></p> <p><b>Facility Fees</b></p> <p><b>Doctor and other services</b></p>	<p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b><u>Recovery &amp; Rehabilitation</u></b></p> <p><b>Home Health Care</b></p> <p><i>Coverage is limited to 100 visits per benefit period.</i></p>	<p>10% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>
<p><b>Rehabilitation services</b></p> <p>Office</p>	<p>10% coinsurance after deductible is met</p>	<p>40% 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	40% coinsurance after deductible is met
<b>Cardiac rehabilitation</b>  Office  Outpatient Hospital	10% coinsurance after deductible is met  10% coinsurance after deductible is met	40% coinsurance after deductible is met  40% coinsurance after deductible is met
<b>Skilled Nursing Care (facility)</b> <i>Coverage is limited to 100 days per benefit period.</i>	10% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Inpatient Hospice</b>	No charge	40% coinsurance after deductible is met
<b>Durable Medical Equipment</b>	10% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Prosthetic Devices</b>	10% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Not covered	Not covered
Pharmacy Out of Pocket	Not covered	Not covered
<b>Prescription Drug Coverage</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 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.
- Outpatient Facility tests and treatments are limited to \$350 per day for Non-Network Providers. Includes Diagnostic Services, X-ray, Surgery, Rehabilitation, Habilitation, and Cardiac Therapy. This also includes Surgery at Freestanding Facilities. Advanced Diagnostic Imaging is limited to \$800 per test 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.*

Your Plan: PRISM (CSURMA): Custom Premier PPO 500/20/90/60

Your Network: Prudent Buyer PPO

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

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

CA/LG/PRISM (CSURMA): Custom Premier PPO//01-01-2023

# 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

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 nta wd 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៖ តើអ្នកអាចអានប៊ិចត្រង់នេះ? ប៊ិចត្រង់នេះ យើងអាចផ្តល់ជំនួយដល់អ្នកដែលមិនអាចអានបាន។ អ្នកក៏អាចទទួលបានជំនួយដើម្បីយល់ពីអ្វីដែលអ្នកកំពុងអាន។ តើអ្នកទទួលបានជំនួយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទឱ្យយើងឈឺ 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 1-888-254-2721로 전화하십시오. (TTY/TDD: 711)

**Punjabi**  
ਮਹਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ, ਤਾਂ ਸਾਨੂੰ ਨਿਯੁਕਤ ਕਰਮਚਾਰੀਆਂ ਨੂੰ ਆਪਣੇ ਭਾਸ਼ਣ ਵਿੱਚ ਸਹਾਇਤਾ ਦੀ ਸੇਵਾ ਪ੍ਰਦਾਨ ਕਰਨ ਦੀ ਸਲਾਹ ਦਿੱਤੀ ਜਾ ਸਕਦੀ ਹੈ। ਆਪਣੇ ਭਾਸ਼ਣ ਵਿੱਚ ਲਿਖਿਆ ਗਿਆ ਪੱਤਰ ਪੜ੍ਹਨ ਵਿੱਚ ਸਹਾਇਤਾ ਲਈ, ਕਰਜ਼ਾ ਨੰਬਰ 1-888-254-2721 ਤੱਕ ਕਾਲ ਕਰੋ। (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 เราสามารถจัดหาเจ้าหน้าที่อ่านให้อ่าน หรืออาจให้เจ้าหน้าที่ช่วยแปลจดหมายในภาษาของท่านก็ได้ โดยไม่ต้องเสียค่าใช้จ่าย อยากรับความช่วยเหลือฟรี โทรหาเราที่หมายเลข 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, a 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 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.





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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