Your summary of benefits

Anthem®

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**
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. **Your copays, coinsurance and deductible count toward your out of pocket amount(s).**		
Preventive Care / Screening / Immunization	**No charge**	**Not covered**
Preventive Care for Chronic Conditions *per IRS guidelines*	**No charge**	**Not covered**
<u>Virtual Care (Telemedicine / Telehealth Visits)</u> **Virtual Visits - Online visits with Doctors who also provide services in person**		
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
Virtual Visits from Online Provider LiveHealth Online *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*		
Primary Care (PCP) and Mental Health and Substance Use Disorder	No charge	Not covered
Specialist Care	$15 copay per visit deductible does not apply	Not covered
Visits in an Office		
Primary Care (PCP)	$15 copay per visit deductible does not apply	Not covered
Specialist Care	$15 copay per visit deductible does not apply	Not covered
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	$15 copay per visit deductible does not apply	Not covered
Retail Health Clinic	$15 copay per visit deductible does not apply	Not covered
Manipulation Therapy *Coverage is limited to 24 visits per benefit period. Limit is combined with Physical Therapy and Occupational Therapy.*	10% coinsurance after the deductible is met	Not covered
Acupuncture *Coverage is limited to 12 visits per benefit period.*	10% coinsurance after the deductible is met	Not covered
Other Services in an Office		
Allergy Testing	10% coinsurance after the deductible is met	Not covered
Chemo/Radiation Therapy	10% coinsurance after the deductible is met	Not covered
Dialysis/Hemodialysis	10% coinsurance after the deductible is met	Not covered
Prescription Drugs *Dispensed in the office*	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
Surgery	**10% coinsurance after the deductible is met**	**Not covered**
<u>Diagnostic Services</u> **Lab**		
Office	**10% coinsurance after the deductible is met**	**Not covered**
Freestanding Lab	**10% coinsurance after the deductible is met**	**Not covered**
Outpatient Hospital	**10% coinsurance after the deductible is met**	**Not covered**
X-Ray		
Office	**10% coinsurance after the deductible is met**	**Not covered**
Freestanding Radiology Center	**10% coinsurance after the deductible is met**	**Not covered**
Outpatient Hospital	**10% coinsurance after the deductible is met**	**Not covered**
Advanced Diagnostic Imaging ***for example: MRI, PET and CAT scans***		
Office	**10% coinsurance after the deductible is met**	**Not covered**
Freestanding Radiology Center	**10% coinsurance after the deductible is met**	**Not covered**
Outpatient Hospital	**10% coinsurance after the deductible is met**	**Not covered**
<u>Emergency and Urgent Care</u>		
Urgent Care	**$15 copay per visit deductible does not apply**	**Not covered**
Emergency Room Facility Services ***Copay waived if admitted.***	**$100 copay per visit and then 10% coinsurance after deductible is met**	**Covered as In-Network**
Emergency Room Doctor and Other Services	**10% coinsurance after the deductible is met**	**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**
Outpatient Mental Health and Substance Use Disorder		
Doctor Office Visit	**$15 copay per visit deductible does not apply**	**Not covered**
Facility Visit		
Facility Fees	**10% coinsurance after the deductible is met**	**Not covered**
Doctor Services	**10% coinsurance after the deductible is met**	**Not covered**
Outpatient Surgery		
Facility Fees		
Hospital	**10% coinsurance after the deductible is met**	**Not covered**
Freestanding Surgical Center	**10% coinsurance after the deductible is met**	**Not covered**
Doctor and Other Services		
Hospital	**10% coinsurance after the deductible is met**	**Not covered**
Hospital (Including Maternity, Mental Health and Substance Use Disorder)		
Facility Fees	**10% coinsurance after the deductible is met**	**Not covered**
Doctor and other services	**10% coinsurance after the deductible is met**	**Not covered**
Recovery & Rehabilitation		
Home Health Care ***Coverage is limited to 100 visits per benefit period.***	**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 ***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.***		
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) ***Coverage is limited to 100 days per benefit period.***	**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 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)

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៖ តើអ្នកអាចអានលិខិតនេះបាន? បើមិនអាចទេ បើអ្នកអាចឱ្យនរណាម្នាក់អានវាជូនអ្នកបាន។ អ្នកក៏អាចទទួលលិខិតនេះជាភាសាសម្រាប់អ្នកផងដែរ។ ដើម្បីទទួលជំនួយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទលេខ 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

หมายเหตุสำคัญ: ท่านสามารถอ่านจดหมายฉบับนี้ รือไม่ หากท่านไม่สามารถอ่านจดหมายฉบับนี้ เราสามารถจัดหาเจ้าหน้าที่ ามาอ่านให้ท่านฟังได้ ท่านยังอาจให้เจ้าหน้าที่ เขียนจดหมายในภาษาของท่านอีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อที่ มายเลข 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

online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.