# Your summary of benefits

Anthem

Anthem® Blue Cross

Your Plan: Fremont Union HSD: Modified PPO PC1 Basic-Major Medical

Your Network: Prudent Buyer PPO

We believe this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. If you have questions about grandfathered health plans, please call the Member Services number on the back of your ID card.

| Visits with Virtual Care-Only Providers | Cost through our mobile app and website |
|---|---|
| **Primary Care, and medical services for urgent/acute care** | $20 copay per visit deductible does not apply |
| **Mental Health & Substance Use Disorder Services** | $20 copay per visit deductible does not apply |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|
| **Major Medical Services Deductible**<br>*Deductible applies to Major Medical Only.* | $250 person / maximum of three separate deductibles per family | $250 person / maximum of three separate deductibles per family |
| **Major Medical Services Out-of-Pocket Limit**<br>*Out-of-Pocket applies to Major Medical Only.* | $1,000 person / calendar year | $2,000 person / calendar year |
| The family deductible is embedded, meaning the cost shares of one family member will be applied to the per person deductible; in addition, amounts for all covered family members apply to the family deductible.<br>No one member will pay more than the per person deductible or per person out-of-pocket limit.<br>Your copays and coinsurance for Major Medical Benefits (Major) count toward your Major Medical Benefits out of pocket limit(s). Copays and deductibles for Basic Medical Benefits (Basic) and Prescription drugs are excluded from the Major Medical Benefits out-of-pocket limit.<br>In-Network and Non-Network deductibles accumulate toward each other; however In-Network and Non-Network out-of-pocket limit amounts accumulate separately and do not accumulate toward each other. | | |
| **Doctor Visits (virtual and office)** *You are encouraged to select a Primary Care Physician (PCP).* | | |
| **Basic: Primary Care (PCP) and Mental Health and Substance Use Disorder Services** *virtual and office* | $20 copay per visit deductible does not apply | 40% coinsurance deductible does not apply |
| **Basic: Specialist Provider** *virtual and office* | $20 copay per visit deductible does not apply | 40% coinsurance deductible does not apply |
| **Other Practitioner Visits** | | |
| **Basic: Maternity services** | | |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|
| Prenatal and Postpartum care | $20 copay per visit deductible does not apply | 40% coinsurance deductible does not apply |
| Delivery | No charge | 40% coinsurance deductible does not apply |
| **Basic: Retail Health Clinic** *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.* | $20 copay per visit deductible does not apply | 40% coinsurance deductible does not apply |
| **Basic: Manipulation Therapy** *Coverage is limited to 24 visits per benefit period.* | $20 copay per visit deductible does not apply | 40% coinsurance deductible does not apply |
| **Basic: Acupuncture** *Coverage is limited to 12 visits per benefit period.* | $20 copay per visit deductible does not apply | 40% coinsurance deductible does not apply |
| **Other Services in an Office** | | |
| **Basic: Allergy Testing** | No charge | 40% coinsurance deductible does not apply |
| **Basic: Prescription Drugs** *Dispensed in the office* | No charge | 40% coinsurance deductible does not apply |
| **Basic: Surgery** | No charge | 40% coinsurance deductible does not apply |
| **Preventive care / screenings / immunizations** | No charge | 40% coinsurance after deductible is met |
| **Preventive Care for Chronic Conditions** *per IRS guidelines* | No charge | Cost share is based on the setting services are received. |
| **Basic: Diagnostic Services Lab** | | |
| Office | No charge | 40% coinsurance deductible does not apply |
| Freestanding Lab | No charge | 40% coinsurance deductible does not apply |
| Outpatient Hospital | No charge | 40% coinsurance deductible does not apply |
| **Diagnostic Services X-Ray** | | |
| Office | No charge | 40% coinsurance deductible does not apply |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|
| Freestanding Radiology Center | No charge | 40% coinsurance deductible does not apply |
| Outpatient Hospital | No charge | 40% coinsurance deductible does not apply |
| **Diagnostic Services Advanced Diagnostic Imaging** *for example: MRI, PET and CAT scans* | | |
| Office | No charge | 40% coinsurance deductible does not apply |
| Freestanding Radiology Center | No charge | 40% coinsurance deductible does not apply |
| Outpatient Hospital | No charge | 40% coinsurance deductible does not apply |
| **Basic: Emergency and Urgent Care** | | |
| **Urgent Care** *includes doctor services. Additional charges may apply depending on the care provided.* | $20 copay per visit deductible does not apply | 40% coinsurance deductible does not apply |
| **Emergency Room Facility Services** *$100 ER deductible for emergency room services waived if admitted directly from ER.* | $100 ER deductible per visit and then no charge | $100 ER deductible per visit and then 40% coinsurance deductible does not apply |
| **Emergency Room Doctor and Other Services** | No charge | 40% coinsurance deductible does not apply |
| **Ambulance** *Basic Surface Ambulance* | $50 copay per trip deductible does not apply | Covered as In-Network |
| *Basic Air Ambulance* | $200 copay per trip deductible does not appl | |
| **Basic: Outpatient Mental Health and Substance Use Disorder Services at a Facility** | | |
| **Facility Fees** | No charge | 40% coinsurance deductible does not apply |
| **Doctor Services** | No charge | 40% coinsurance deductible does not apply |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|
| **Basic: Outpatient Surgery** | | |
| **Facility Fees** | | |
| Hospital | No charge | 40% coinsurance deductible does not apply |
| Ambulatory Surgical Center | No charge | 40% coinsurance deductible does not apply |
| **Physician and other services** *including surgeon fees* | | |
| Hospital | No charge | 40% coinsurance deductible does not apply |
| **Basic: Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)** | | |
| **Facility Fees** | No charge | 40% coinsurance deductible does not apply |
| **Physician and other services** *including surgeon fees* | No charge | 40% coinsurance deductible does not apply |
| **Basic: Home Health Care**<br>*Coverage is limited to 100 visits per benefit period.* | No charge | 40% coinsurance deductible does not apply |
| **Basic: Rehabilitation and Habilitation services – Physical and Occupational Therapies** *office and outpatient hospital*<br>*Coverage is limited to 24 visits per benefit period.* | No charge | 40% coinsurance deductible does not apply |
| **Major: Rehabilitation and Habilitation services – Speech Therapy** *office and outpatient hospital* | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Basic: Pulmonary rehabilitation** *office and outpatient hospital* | No charge | 40% coinsurance deductible does not apply |
| **Basic: Cardiac rehabilitation** *office and outpatient hospital* | No charge | 40% coinsurance deductible does not apply |
| **Basic: Dialysis/Hemodialysis** *office and outpatient hospital* | No charge | 40% coinsurance deductible does not apply |
| **Basic: Chemo/Radiation Therapy** *office and outpatient hospital* | No charge | 40% coinsurance deductible does not apply |
| **Basic: Skilled Nursing Care (facility)**<br>*Coverage is limited to 100 days per benefit period.* | No charge | 40% coinsurance deductible does not apply |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|
| **Major: Inpatient Hospice** | 20% coinsurance after deductible is met | 20% coinsurance after deductible is met |
| **Additional Services, Equipment and Devices** | | |
| **Major: Durable Medical Equipment** | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Major: Prosthetic Devices** | 20% coinsurance after deductible is met | 40% coinsurance after deductible is met |
| **Major: Hearing Aids**<br>*Coverage is limited to 1 item per ear every 36 Months.* | 20% coinsurance after deductible is met | 40% coinsurance after 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 applicable | Not applicable |
| **Pharmacy Out-of-Pocket Limit** | Not applicable | Not applicable |
| **Prescription Drug Coverage**<br>**Network:** ***Base Network***<br>**Drug List:** ***CA National DMHC*** *If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.* | | |
| **Day Supply Limits:**<br>**Retail Pharmacy** *30 day supply (cost shares noted below)*<br>**Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.*<br>**Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.* | | |
| **Tier 1 - Typically Generic** | $10 copay per prescription (retail) and $20 copay per prescription (home delivery) | $10 copay per prescription plus 50% coinsurance (retail) and Not covered (home delivery) |
| **Tier 2 - Typically Preferred Brand** | $30 copay per prescription (retail) and $60 copay per prescription (home delivery) | $30 copay per prescription plus 50% coinsurance (retail) and Not covered (home delivery) |
| **Tier 3 - Typically Non-Preferred Brand** | $50 copay per prescription (retail) and $100 copay per prescription (home delivery) | $50 copay per prescription plus 50% coinsurance (retail) and Not covered (home delivery) |

| Covered Prescription Drug Benefits | Cost if you use an In-Network Pharmacy | Cost if you use an Out-of-Network Pharmacy |
|---|---|---|
| **Tier 4 - Typically Specialty (brand and generic)** | 20% coinsurance up to $150 per prescription (retail) and 20% coinsurance up to $300 per prescription (home delivery) | 50% coinsurance (retail) and Not covered (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.
- 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.
- The representations of benefits in this document are subject to California Department of Managed Health Care (DMHC) approval and are subject to change.

*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.*



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, please call right away at 1-888-254-2721. (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, podemos pedirle a alguien que le ayude a leerla. También es posible que pueda solicitar que le enviemos esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721 (TTY/TDD: 711).

**Arabic**

هام: هل تستطيع قراءة هذه الرسالة؟ إذا لم يكن الأمر كذلك، يمكننا أن نطلب من شخص ما مساعدتك في قراءتها. قد تتمكن أيضًا من الحصول على هذه الرسالة مكتوبة بلغتك. للحصول على مساعدة مجانية، يرجى الاتصال على الفور على الرقم 1-888-254-2721. (TTY/TDD: 711)

**Armenian**

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք կարդալ այս նամակը: Եթե ոչ, մենք կարող ենք առաջարկել որևէ մեկի օգնությունը՝ ձեզ համար այն կարդալու համար: Դուք կարող եք նաև այս նամակը ստանալ ձեր լեզվով: Անվճար օգնության համար խնդրում ենք անմիջապես զանգահարել՝ 1-888-254-2721. (TTY/TDD: 711)

**Chinese**

重要：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。如需免費幫助，請立即致電 1-888-254-2721. (TTY/TDD:711)

**Farsi**

مهم: آیا می توانید این نامه را بخوانید؟ اگر نخوانیدنمی توانیم از شخصی بخواهیم که برای شما نامه را بخواند. کتبی صورت به را نامه این بتوانید است ممکن همچنین به زبان خود دریافت کنید. برای دریافت کمک فوراً با ما تماس بگیرید. شماره تماس (TTY/TDD: 711) 1-888-254-2721.

**Hindi**

**महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में किसी की मदद ले सकते हैं। यह पत्र आप अपनी भाषा में भी लिखवा सकते हैं। निःशुल्क सहायता के लिए, कृपया तुरंत 1-888-254-2721 पर कॉल करें। (टीटीवाई/टीडीडी:711)**

**Hmong**

TSEEM CEEB: Koj puas nyeem tau daim ntawv no? Yog tias tsis tau, peb muaj qee tus neeg pab nyeem nws rau koj. Koj los kuj yuav tau txais ib daim ntawv sau ua kom yam lus. Rau kev pab dawb, thov hu tam sim ntawm 1-888-254-2721. (TTY/TDD: 711)

**Japanese**

重要：この文書を読むことができますか？読むことができない場合、支援することが可能です。また、日本語で訳されたこの文書を書面で受け取ることができます。無料の支援をご希望の場合、1-888-254-2721（TTY/TDD:711）にご連絡ください。

**Khmner**

សំខាន់៖ តើអ្នកអាចអានសំបុត្រនេះបានទេ? បើអត់ទេ យើងអាចមានអ្នកជួយអាន។ អ្នកក៏អាចទទួលបានសំបុត្រនេះសរសេរជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមទូរស័ព្ទមកភ្លាមៗតាមរយៈលេខ 1-888-254-2721. (TTY/TDD: 711)

**Korean**
중요: 이 편지를 읽으실 수 있으신가요? 그렇지 않으신 경우, 이를 읽으실 수 있도록 도움을 제공해 드릴 수 있습니다. 귀하의 모국어로 된 편지를 우편으로 받아보실 수도 있습니다. 무상으로 제공되는 도움이 필요하신 경우, 1-888-254-2721번으로 바로 연락해 주십시오. (TTY/TDD: 711)

**Punjabi**
ਕੀ ਤੁਸੀ ਇਹ ਚਿੱਠੀ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀ, ਤਾਂ ਅਸੀ ਇਸਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਸ ਚਿੱਠੀ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵੀ ਲਿਖ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਤੁਰੰਤ ਇਸ 'ਤੇ ਕਾਲ ਕਰੋ 1-888-254-2721। (TTY/TDD: 711)

**Russian**
ВАЖНАЯ ИНФОРМАЦИЯ: 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: Mababasa mo ba ang sulat na ito? Kung hindi, mayroon kaming makakatulong sa iyo na basahin ito. Maaari mo ring makuha ang sulat na ito nang nakasulat sa iyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

**Thai**
สำคัญ: คุณสามารถอ่านจดหมายนี้ได้หรือไม่ หากคุณอ่านจดหมายนี้ไม่ได้ เราสามารถขอให้ใครสักคนช่วยคุณอ่านได้ คุณสามารถร้องขอจดหมายนี้ที่เขียนในภาษาของคุณได้เช่นกัน หากต้องการความช่วยเหลือแบบไม่มีค่าใช้จ่าย โปรดโทรหาเราได้ทันทีที่ 1-888-254-2721. (TTY/TDD: 711)

**Vietnamese**
QUAN TRỌNG: Quý vị có đọc được lá thư này không? Nếu không, chúng tôi có thể nhờ ai đó giúp quý vị đọc. Quý vị cũng có thể yêu cầu thư này viết bằng ngôn ngữ của quý vị. Để được trợ giúp miễn phí, hãy gọi ngay đến số 1-888-254-2721. (TTY/TDD: 711)

## It's important we treat you fairly

We follow state and federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services, in a timely manner, like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or if you think you were discriminated against based on race, color, national origin, age, disability, or sex, you can mail a complaint directly to 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. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf