

Your summary of benefits



Anthem® Blue Cross

Your Plan: Custom Anthem Link EPO HSA 2500/20 (Consumer Choice)

Your Network: Anthem High Performance

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$2,500 person / \$5,000 family	Not applicable
Out-of-Pocket Limit	\$6,150 person / \$12,300 family	Not applicable
<p>Calendar Year Deductible. Each year, you will be responsible for satisfying the member's Calendar Year Deductible before the plan begins to pay medical and prescription drug benefits. If members of an enrolled family pay deductible expense in a year equal to the Family Deductible, the Calendar Year Deductible for all family members will be considered to have been met.</p> <p>The family out-of-pocket maximum is embedded meaning the cost shares of one family member will be applied to the individual out-of-pocket maximum; in addition, amounts for all covered family members apply to the family out-of-pocket maximum. No one member will pay more than the individual out-of-pocket maximum.</p>		
Preventive Care / Screening / Immunization	No charge	Not covered
<u>Doctor Home and Office Services</u>		
Primary Care Visit	20% coinsurance after deductible is met	Not covered
Specialist Care Visit	20% coinsurance after deductible is met	Not covered
Prenatal and Post-natal Care	20% coinsurance after deductible is met	Not covered
<u>Other Practitioner Visits:</u>		
Retail Health Clinic	20% coinsurance after deductible is met	Not covered
Preferred On-line Visit <i>Includes Mental/Behavioral Health and Substance Abuse</i>	0% coinsurance after deductible is met	Not covered
Manipulation Therapy <i>Coverage is limited to 24 visits per benefit period.</i>	20% coinsurance after deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<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>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><u>Diagnostic Services</u></p> <p>Lab:</p> <p>Office</p> <p>Freestanding Lab</p> <p>Outpatient Hospital</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p>X-Ray:</p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p>Advanced Diagnostic Imaging:</p> <p>Office</p> <p>Freestanding Radiology Center</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</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
Outpatient Hospital	20% coinsurance after deductible is met	Not covered
<u>Emergency and Urgent Care</u> Urgent Care	20% coinsurance after deductible is met	Not covered
Emergency Room Facility Services Emergency Room Doctor and Other Services	20% coinsurance after deductible is met 20% coinsurance after deductible is met	Covered as In-Network Covered as In-Network
<u>Ambulance</u>	20% coinsurance after deductible is met	Covered as In-Network
<u>Outpatient Mental/Behavioral Health and Substance Abuse</u> Doctor Office Visit Facility Visit: Facility Fees Doctor Services	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	Not covered Not covered Not covered
<u>Outpatient Surgery</u> Facility Fees: Hospital Freestanding Surgical Center Doctor and Other Services: Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	Not covered Not covered Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><u>Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):</u></p> <p>Facility Fees</p> <p>Doctor and other services</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>Not covered</p> <p>Not covered</p>
<p><u>Recovery & Rehabilitation</u></p> <p>Home Health Care <i>Coverage is limited to 100 visits per benefit period.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>Not covered</p>
<p>Rehabilitation services:</p> <p>Office <i>Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 60 visits per benefit period. Speech therapy limited to 30 visits per benefit period.</i></p> <p>Outpatient Hospital <i>Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 60 visits per benefit period. Speech therapy limited to 30 visits per benefit period.</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>Not covered</p> <p>Not covered</p>
<p>Cardiac rehabilitation</p> <p>Office <i>Coverage is limited to 36 visits per benefit period.</i></p> <p>Outpatient Hospital <i>Coverage is limited to 36 visits per benefit period.</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>Not covered</p> <p>Not covered</p>
<p>Skilled Nursing Care (facility) <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 60 days combined per benefit period.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>Not covered</p>
<p>Hospice</p>	<p>20% coinsurance after deductible is met</p>	<p>Not covered</p>
<p>Durable Medical Equipment</p>	<p>20% coinsurance after deductible is met</p>	<p>Not covered</p>
<p>Prosthetic Devices</p>	<p>20% coinsurance after deductible is met</p>	<p>Not covered</p>
<p>Hearing Aids <i>Limited to \$2,500 maximum every 3 years.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>Not covered</p>
<p>Wigs <i>Limited to \$500 maximum per year.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>Not covered</p>

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Combined with medical deductible	Not applicable
Pharmacy Out of Pocket	Combined with medical	Not applicable
Prescription Drug Coverage <i>National with R90</i> <i>This plan uses an Essential Drug List.</i> <i>This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs. Drugs not on the list are not covered.</i>		
Preventive Drugs <i>This plan has Preventive RX coverage that allows the member designated Preventive drugs at the cost shares listed below.</i>		
Tier 1a - Typically Lower Cost Generic	No charge	Not covered
Tier 1b - Typically Generic	No charge	Not covered
Tier 2 - Typically Preferred Brand	No charge	Not covered
Tier 1 - Typically Lower Cost Generic <i>30 day supply (retail pharmacy). 90 day supply (home delivery).</i>	\$10 copay per prescription after deductible is met (retail) and \$25 copay per prescription after deductible is met (home delivery)	Not covered
Tier 2 – Typically Preferred Brand <i>30 day supply (retail pharmacy). 90 day supply (home delivery).</i>	35% coinsurance with \$45 minimum and \$90 maximum copay per prescription after deductible is met (retail) and \$75 copay per prescription after deductible is met (home delivery)	Not covered

<p>Tier 3 - Typically Non-Preferred Brand 30 day supply (retail pharmacy). 90 day supply (home delivery).</p>	35% coinsurance with \$75 minimum and \$150 maximum copay per prescription after deductible is met (retail) and \$125 copay per prescription after deductible is met (home delivery)	Not covered
<p>Tier 4 - Typically Specialty (brand and generic) 30 day supply (retail pharmacy). 30 day supply (home delivery).</p>	\$125 copay per prescription after deductible is met (retail and home delivery)	Not covered

Notes:

- 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.
- 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” which is generally coinsurance or coinsurance after your deductible is met.
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.

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.

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

ՌԻՇԱԴՐՈՒԹՅՈՒՆ. 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 tamsim 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៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ យើងអាចឱ្យនរណាម្នាក់អានវាជូនអ្នក។ អ្នកក៏អាចទទួលបានលិខិតនេះដោយសេរីដោយសារការសម្របសម្រួលផងដែរ។ ដើម្បីទទួលបានជំនួយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅលេខ 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

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹ ਤਾਂ ਅਸ ਇਸ ਨੂੰ ਪੜ੍ਹਾਓ ਿਵੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਿਕਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸ ਸਾਇਦ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਿਵੱਚ ਿਲਿਖਿਆ ਹੋਇਆ ਵਬੀ ਪ੍ਰਾਪ ਾਪ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮਦਦ ਲਈ, ਿਕਰਪਾ ਕਰਕੇ ਫੋਰਨ 1-888-254-2721 ਤੇ 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 เราสามารถจัดหาเจ้าหน้าที่มาอ่านให้ท่านฟังได้ ท่านยังอาจให้เจ้าหน้าที่ช่วยเขียนจดหมายในภาษาของท่านอีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อที่หมายเลข 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, 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, NE, Washington, DC 20201. 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.

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>.

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