Your summary of benefits

Anthem® Blue Cross

Your Plan: ALADS Custom 2023 Classic PPO

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	$300 single / $900 family	$300 single / $900 family
Out-of-Pocket Limit	$450 single / $1,350 family	$6,000 single / $18,000 family
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). In-network and out-of-network deductibles are combined and accumulate toward each other; however, in-network and out-of-network out-of-pocket maximum amounts accumulate separately and do not accumulate toward each other.		
Preventive Care / Screening / Immunization	No charge medical deductible does not apply	30% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge medical deductible does not apply	30% coinsurance after medical deductible is met
Virtual Care (Telemedicine / Telehealth Visits) **Virtual Visits - Online visits with Doctors who also provide services in person**		
Primary Care Physician (PCP)	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Specialist Care	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Virtual Visits from Online Provider LiveHealth Online *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Primary Care Physician (PCP)	10% coinsurance after medical deductible is met	
Specialist Care	10% coinsurance after medical deductible is met	
Visits in an Office		
Primary Care Physician **(PCP)**	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Specialist Care	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Retail Health Clinic	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Manipulation Therapy	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Acupuncture *Coverage for In-Network and Non-Network is limited to 12 visits per benefit period. Benefits are to be managed by the American Specialty Health (ASH) guidelines.*	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Other Services in an Office		
Allergy Testing and Treatment *Includes serums.*	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Chemo/Radiation Therapy	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Dialysis/Hemodialysis	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Prescription Drugs *Dispensed in the office* *Maximum of $250 member cost share per drug.*	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Surgery	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Diagnostic Services **Lab**		
Office	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Freestanding Lab	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Outpatient Hospital	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
X-Ray		
Office	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Freestanding Radiology Center	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Outpatient Hospital	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Freestanding Radiology Center	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Outpatient Hospital	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency and Urgent Care		
Urgent Care	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Emergency Room Facility Services	10% coinsurance after medical deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	10% coinsurance after medical deductible is met	Covered as In-Network
Ambulance	20% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Surgery		
Facility Fees		
Hospital	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Freestanding Surgical Center	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Doctor and Other Services		
Hospital	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Hospital (Including Maternity)		
Facility Fees (for example, room & board)	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Doctor and other services	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage for In-Network and Non-Network is limited to 100 visits per benefit period.*	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Rehabilitation and Habilitation services (Including Physical Therapy, Occupational Therapy and Speech Therapy)		
Office	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Outpatient Hospital	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Cardiac rehabilitation		
Office	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Outpatient Hospital	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Skilled Nursing Care (facility)	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Inpatient Hospice	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Durable Medical Equipment *Hearing aid benefit is available for one hearing aid per ear every three years.*	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Prosthetic Devices	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Temporomandibular Joint Disorders	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Refractive Eye Surgeries *Including astigmatic keratotomy, lamellar kerotoplasy and laser procedures for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia), hyperopia (farsightedness) or astigmatism. Limited to a lifetime benefit of $1,500/eye.*	10% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Prescription Drug Coverage *Cost shares for drugs included on the National drug list appear below. Drugs not included on the National drug list will not be covered. Your plan uses the Base Network.*		
Home Delivery Pharmacy *Maintenance medication are available through IngenioRx 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.*		
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy).* *Per 90 day supply (home delivery).* *Per 30 day supply (specialty pharmacy).*	$5 copay per prescription (retail and specialty) and $5 copay per prescription (home delivery)	50% coinsurance up to $250 per prescription (retail) and Not covered (specialty and home delivery)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy).* *Per 90 day supply (home delivery).* *Per 30 day supply (specialty pharmacy).*	$15 copay per prescription (retail and specialty) and $5 copay per prescription (home delivery)	50% coinsurance up to $250 per prescription (retail) and Not covered (specialty and home delivery)
Tier 3 - Typically Non-Preferred Brand *Per 30 day supply (retail pharmacy).* *Per 90 day supply (home delivery).* *Per 30 day supply (specialty pharmacy).*	$15 copay per prescription (retail and specialty) and $5 copay per prescription (home delivery)	50% coinsurance up to $250 per prescription (retail) and Not covered (specialty 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.
- 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.
- Mental health and substance abuse benefits covered by The Holman Group.

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 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៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ យើងអាចឲ្យនរណាម្នាក់អានវាជូនអ្នក។ អ្នកក៏អាចទទួលលិខិតនេះដោយសរសេរជាភាសារបស់អ្នកផងដែរ។ ដើម្បីទទួលជំនួយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមទៅលេខ 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 ਪੜਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹ, ਤਾਂ ਅਸ ਇਸ ਨੂੰ ਪੜਹ ਿਵੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਿਕਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸ ਸ਼ਾਇਦ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਿਵੱਚ ਿਲਖਆ ਹੋਇਆ ਵਬੀ ਪਰ੍ਾਪ ੍ਾਪ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਮਦਦ ਲਈ, ਿਕਰਪਾ ਕਰਕੇ ਫੈਰਨ 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, 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.