Your summary of benefits

Anthem

Anthem® Blue Cross Life and Health Insurance Company

Your Plan: Student Health Insurance Plan

Your School: Azusa Pacific University - SHIP

Your Network: Prudent Buyer PPO

Visits with Virtual Care-Only Providers available through our mobile app and website	
Primary Care, and medical services for urgent/acute care	$25 copay per visit deductible does not apply
Mental Health & Substance Use Disorder Services	$25 copay per visit deductible does not apply
Specialist care	$25 copay per visit deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$150 person	$300 person
Overall Out-of-Pocket Limit	$8,000 person / $10,000 family	No maximum
The family out-of-pocket maximum is embedded, meaning the cost shares of one family member will be applied to the per person 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 per person out-of-pocket maximum. All medical and prescription drugs deductibles, copayments and coinsurance apply toward the out-of-pocket maximum. In-network and out-of-network deductibles are separate and do not accumulate toward each other.		
Primary Care (PCP) *virtual and office*	$25 copay per visit deductible does not apply	**Office** $25 copay per visit and then 40% coinsurance deductible does not apply **Virtual** $25 copay per visit and then 40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Mental Health and Substance Use Disorder Care *virtual and office*	$25 copay per visit deductible does not apply	$25 copay per visit and then 40% coinsurance deductible does not apply
Specialist Care *virtual and office*	$25 copay per visit deductible does not apply	**Office** $25 copay per visit and then 40% coinsurance deductible does not apply **Virtual** $25 copay per visit and then 40% coinsurance after deductible is met
Other Practitioner Visits		
Routine Maternity Care Prenatal Preventive Care	No charge	$25 copay per visit and then 40% coinsurance deductible does not apply
Postnatal Office Visit	No charge	$25 copay per visit and then 40% coinsurance deductible does not apply
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$25 copay per visit deductible does not apply	$25 copay per visit and then 40% coinsurance after deductible is met
Chiropractic Services *Coverage is limited to 20 visits per year.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Acupuncture	$25 copay per visit after deductible is met	$25 copay per visit and then 40% coinsurance after deductible is met
Other Services in an Office		
Allergy Testing	Covered according to the type of benefit and the place where the service is rendered	Covered according to the type of benefit and the place where the service is rendered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prescription Drugs - *Dispensed in the office*	$25 copay per visit after deductible is met	40% coinsurance after deductible is met
Surgery	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	$25 copay per visit and then 40% coinsurance deductible does not apply
Preventive care for Chronic Conditions *per IRS guidelines*	No charge	$25 copay per visit and then 40% coinsurance deductible does not apply
Diagnostic Services		
Lab		
Office	$25 copay per visit deductible does not apply	$25 copay per visit and then 40% coinsurance after deductible is met
Freestanding Lab	$25 copay per visit deductible does not apply	$25 copay per visit and then 40% coinsurance after deductible is met
Outpatient Hospital	$25 copay per visit deductible does not apply	$25 copay per visit and then 40% coinsurance after deductible is met
X-Ray		
Office	$25 copay per visit deductible does not apply	$25 copay per visit and then 40% coinsurance after deductible is met
Freestanding Radiology Center	$25 copay per visit deductible does not apply	$25 copay per visit and then 40% coinsurance after deductible is met
Outpatient Hospital	$25 copay per visit deductible does not apply	$25 copay per visit and then 40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Advanced Diagnostic Imaging		
Office	$25 copay per visit deductible does not apply	$25 copay per visit and then 40% coinsurance after deductible is met
Freestanding Radiology Center	$25 copay per visit deductible does not apply	$25 copay per visit and then 40% coinsurance after deductible is met
Outpatient Hospital	$25 copay per visit deductible does not apply	$25 copay per visit and then 40% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care in an Office Setting	$25 copay per visit deductible does not apply	$25 copay per visit and then 40% coinsurance after deductible is met
Emergency Room Facility Services *Your copay will be waived if admitted.*	$100 copay per visit deductible does not apply	Same as In-Network
Emergency Room Doctor and Other Services	No charge	Same as In-Network
Emergency Ambulance	20% coinsurance after deductible is met	Same as In-Network
Outpatient Mental Health and Substance Use Disorder Care at a Facility		
Facility Fees	No charge	40% coinsurance after deductible is met
Doctor Services	No charge	40% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Ambulatory Surgical Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Doctor and Other Services		
Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Ambulatory Surgical Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)		
Facility Fees *Coverage for Skilled Nursing facility is limited to 100 days combined per benefit period.*	20% coinsurance after deductible is met	$250 copay per admission and then 40% coinsurance after deductible is met
Human Organ and Tissue Transplants *Coverage includes acquisition and transplant procedures, collection and storage.*	20% coinsurance after deductible is met	Not covered
Doctor and other services	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Rehabilitation services		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Habilitation services		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Chemo/Radiation Therapy		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Dialysis/Hemodialysis		
Office	$25 copay per visit after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	$25 copay per visit after deductible is met	40% coinsurance after deductible is met
Cardiac rehabilitation		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage for Skilled Nursing is limited to 100 days combined per benefit period.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Hospice	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Durable Medical Equipment	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prosthetic Devices	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Temporomandibular Joint Dysfunction (TMJ) and Craniomandibular Joint Dysfunction (CMJ) Treatment	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Adult Dental Care for Dental Injuries *Does not include injuries resulting from chewing or biting, or orthodontia*	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Impacted Wisdom Teeth Removal	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Reversal of Voluntary Sterilization	20% 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 applicable	Not covered
Pharmacy Out-of-Pocket Limit	Combined with medical out-of-pocket limit	Not covered
Prescription Drug Coverage **Network*: Base Network*** **Drug List: *Traditional Open***		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (cost shares noted below)* **Specialty Pharmacy** *30 day supply (cost shares noted below for retail 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 *Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies.*	$10 copay per prescription (retail) and Not covered (home delivery)	Not covered (retail and home delivery)
Tier 2 – Typically Preferred Brand *Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies.*	$30 copay per prescription (retail) and Not covered (home delivery)	Not covered (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand *Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies.*	$60 copay per prescription (retail) and Not covered (home delivery)	Not covered (retail and home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out-of-pocket limit.		
Children's Vision Essential Health Benefits (up to age 19) **Vision exam** *Limited to 1 exam per benefit period.*	No charge	Reimbursed Up to $30
Frames *Limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $45
Lenses *Limited to 1 unit per benefit period combined with OON Coverage. OON Reimbursement: Single* Reimbursed Up to $25*, Bifocal* Reimbursed Up to $40*, Trifocal* Reimbursed Up to $55.	No charge	Receives Reimbursement
Elective Contact Lenses *Limited to 1 unit per benefit period combined with Non-Elective Contact Lenses.*	No charge	Reimbursed Up to $60
Non-Elective Contact Lenses *Limited to 1 unit per benefit period combined with Elective Contact Lenses.*	No charge	Reimbursed Up to $210

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Adult Vision (age 19 and older) **Adult Vision Coverage**		
Vision exam *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 exam per benefit period.*	$10 copay	$0 copay plus all charges in excess of the maximum allowed amount

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your dental coverage. Only children's dental services count towards your out-of-pocket limit.		
Children's Dental Essential Health Benefits **Diagnostic and preventive** *Limited to 1 visit per 6 months.*	No charge	No charge
Basic services	20% coinsurance deductible does not apply	20% coinsurance deductible does not apply
Major services	50% coinsurance deductible does not apply	50% coinsurance deductible does not apply
Medically Necessary Orthodontia services	50% coinsurance deductible does not apply	50% coinsurance deductible does not apply
Cosmetic Orthodontia services	Not covered	Not covered
Adult Dental	Not covered	Not covered

Notes:

- Members are encouraged to always obtain prior approval when using Non-Network providers. Precertification will help the member know if the services are considered not medically necessary.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-Network provider, the member is responsible for any balance due after the plan payment.
- 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.
- The representations of benefits in this document are subject to California Department of Insurance (DOI) approval and are subject to change.
- For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to https://le.anthem.com/pdf?x=CA_SH_PPOL00274.

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: (800) 888-2108 or visit us at https://student.anthem.com
CA/SH/Anthem CA SHP Prudent Buyer Plan//08-15-2024

Get help in your language

Notice of Language Assistance

Curious to know what all this says? We would be too. Here's the English version:
No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-888-254-2721. For more help call the CA Dept. of Insurance at 1-800-927-4357. (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
Servicios lingüísticos sin costo. Puede tener un intérprete. Puede solicitar que le lean los documentos y algunos puede recibirlos en su idioma. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-888-254-2721. Para obtener ayuda adicional, llame al Departamento de Seguros de California al 1-800-927-4357. (TTY/TDD: 711)

Arabic
يتم تقديم خدمات اللغة دون مقابل. يمكنك الاستعانة بمترجم. ويمكنك المطالبة بأن تُقرأ لك بعض المستندات وأن يُرسل بعضها بلغتك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة التعريف الخاصة بك أو على الرقم 1-888-254-2721.
للحصول على مزيد من المساعدة، يُرجى الاتصال بإدارة كاليفورنيا للتأمين على الرقم 1-800-927-4357. (TTY/TDD: 711)

Armenian
Թարգմանչական անվճար ծառայություններ: Մենք կարող ենք Ձեզ թարգմանչի ծառայություններ առաջարկել Կարող ենք տրամադրել ինչ-որ մեկին, ով փաստաթղթերը կկարդա Ձեզ համար և կուղարկի դրանք Ձեր լեզվով: Օգնություն ստանալու համար զանգահարեք մեզ Ձեզ ID քարտի վրա նշված հեռախոսահամարով կամ 1-888-254-2721 համարով: Լրացուցիչ օգնության համար զանգահարեք Կալիֆոռնիայի ապահովագրության նախարարություն հետևյալ հեռախոսահամարով՝ 1-800-927-4357: (TTY/TDD: 711)

Chinese
免費語言服務。您能獲得免費的譯員。您能聽到以您的語言讀出的文件內容，也能獲得以您的語言而寫的部分文件。如需協助，請撥打您的 ID 卡上的號碼或者1-888-254-2721聯絡我們。如需更多協助，請撥打1-800-927-4357 聯絡CA Dept. of Insurance。(TTY/TDD: 711)

Farsi
خدمات رایگان زبانی. می‌توانید یک مترجم شفاهی بگیرید. می‌توانید بخواهید اسناد را برای شما بخوانند و برخی اسناد نیز به زبان خودتان برایتان ارسال شود. برای دریافت کمک، از طریق شماره فهرست شده در کارت شناسایی‌تان و یا از طریق 1-888-254-2721
با ما تماس بگیرید. برای دریافت کمکهای بیشتر با اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تماس بگیرید. (TTY/TDD:711)

Hindi
बिना लागत की भाषा सेवाएँ। आप दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेज़ पढ़वा सकते हैं और कुछ दस्तावेज़ आपको आपकी भाषा में भेजे जा सकते हैं। मदद के लिए, हमें अपने ID कार्ड पर सूचीबद्ध नंबर पर या 1-888-254-2721 पर कॉल करें। अधिक मदद के लिए 1-800-927-4357 पर CA बीमा विभाग कोकॉल करें। (TTY/TDD: 711)

Hmong
Tsis Xam Tus Nqi Cov Kev Pab Cuam Ntsig Txog Hom Lus. Koj muaj peev xwm tau txais ib tus neeg txhais lus. Koj muaj peev xwm tau txais cov ntaub ntawv nyeem ua koj hom lus rau koj mloog thiab yuav xa ib co ntaub ntawv sau ua koj hom lus tuaj rau koj. Txog rau kev pab, hu rau peb tus nab npawb xov tooj teev tseg cia nyob rau ntawm koj daim ID los sis 1-888-254-2721. Txog rau kev pab ntxiv, hu xov tooj rau Pab Kas Phais Lub Chaw Ua Hauj Lwm CA tus xov tooj 1-800-927-4357. (TTY/TDD: 711)

Japanese
無料言語サービス。通訳サービスを受けられます。希望する言語で文書を読み上げたり、文書を送るサービスも可能です。支援を受けるには、IDカードに記載された番号、または 1-888-254-2721 にお電話ください。支援の詳細は、カリフォルニア州保険局（1-800-927-4357）にお電話ください。(TTY/TDD: 711)

Khmer
សេវាភាសាឥតគិតថ្លៃ។ អ្នកអាចទទួលអ្នកបកប្រែម្នាក់។ អ្នកអាចឲ្យគេអានឯកសារផ្សេងៗជូនអ្នក និងផ្ញើឯកសារជូនអ្នកជាភាសារបស់អ្នក។ ដើម្បីទទួលជំនួយ សូមហៅ ទូរស័ព្ទមកយើងតាមលេខដែលបានរាយនៅលើប័ណ្ណ ID របស់អ្នក ឬក៏លេខ 1-888-254-2721។ ដើម្បីទទួលជំនួយបន្ថែម សូមហៅទូរស័ព្ទទៅ CA Dept. of Insurance តាមលេខ 1-800-927-4357។(TTY/TDD: 711)

Korean
무료 언어 서비스. 번역사를 이용하실 수 있습니다. 귀하의 언어로 녹음되어 작성된 문서를 받아보실 수 있습니다. 도움을 받으시려면 ID 카드에 기재된 번호 또는 1-888-254-2721로 전화하십시오. 다른 도움이 필요하시면 1-800-927-4357로 보험 CA 부서에 문의 주십시오. (TTY/TDD: 711)

Punjabi
ਿਬਨਾਂ ਿਕਸੇ ਲਾਗਤ ਦੇ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸ ਇੱਕ ਦੁਭਾਸ਼ੀਆ ਪਰ੍ਾਪ ਰ੍ਾਪ ਕਰ ਸਕਦੇ ਹੋ। ਕੋਈ ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਪੜਹ ਕੇ ਸੁਣਾ ਸਕਦਾ ਹੈ ਅਤੇ ਕੁਝ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਿਵੱਚ ਤੁਹਾਨੂੰ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਸਾਨੂੰ ਤੁਹਾਡੇ ਆਈਡੀ ਕਾਰਡ ਉਤੇ ਸੂਚੀਬੱਧ ਨੰਬਰ ਜਾਂ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। ਿਜ਼ਆਦਾ ਮਦਦ ਲਈ, ਸੀਏ ਿਡਪਾਰਟਮ ਟ ਔਫ ਇਨਸ਼ੋਰ ਸ ਨੂੰ 1-800-927-4357 ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Russian
Бесплатные языковые услуги. Вы можете получить услуги устного переводчика. Вам могут прочитать документы или направить некоторые из них на вашем языке. Для получения помощи звоните нам по телефону, указанному на вашей идентификационной карте, или по номеру 1-888-254-2721. Для получения дополнительной помощи звоните в Департамент страхования штата Калифорния по номеру 1-800-927-4357. (TTY/TDD: 711)

Tagalog
Mga Libreng Serbisyo para sa Wika. Maaari kayong kumuha ng interpreter. Maaari ninyong ipabasa ang mga dokumento at ipadala ang ilan sa mga ito sa inyo sa wikang ginagamit ninyo. Para sa tulong, tawagan kami sa numerong nakalista sa inyong ID card o sa 1-888-254-2721. Para sa higit pang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. (TTY/TDD: 711)

Thai
ไม่มีค่าบริการเกี่ยวกับภาษา ท่านสามารถขอใช้บริการล่ามได้
ท่านสามารถขอให้เจ้าหน้าที่อ่านเอกสารได้ท่านฟังและเอกสารบางอย่างจะส่งถึงท่านโดยใช้ภาษาของท่าน หากต้องการความช่วยเหลือ โปรดโทรหาเราตามหมายเลขที่ระบุอยู่บนบัตรประจำตัวของท่านหรือที่หมายเลข 1-888-254-2721 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรติดตามแผนก CA Dept. of Insurance ที่หมายเลข 1-800-927-4357 (TTY/TDD: 711)

Vietnamese
Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có thông dịch viên. Quý vị có thể yêu cầu đọc tài liệu cho quý vị nghe và yêu cầu gửi một số tài liệu bằng ngôn ngữ của quý vị cho quý vị. Để được trợ giúp, hãy gọi cho số được ghi trên thẻ ID của quý vị hoặc số 1-888-254-2721. Để được giúp đỡ thêm, hãy gọi cho Sở Bảo Hiểm California (California Department of Insurance) theo số 1-800-927-4357. (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.