

Plan Highlights

Anthem Classic PPO 400

	In-Network	Out-of-Network
Provider Network	CA: Prudent Buyer Large Group Non-CA: National PPO (BlueCard PPO)	Not Applicable
Calendar Year Deductible		
Individual	\$400	
Family	\$1,200	
Calendar Year Out-of-pocket Maximum ⁽¹⁾		
Individual	\$3,500	\$7,000
Family	\$7,000	\$14,000
Lifetime Maximum		
Individual	Unlimited	Unlimited
Professional Services		
Primary Care Physician (PCP)	\$20 Copay / Visit	40% ⁽²⁾
Specialist	\$20 Copay / Visit	40% ⁽²⁾
Preventive Care Exam	No Copay	40% ⁽²⁾
Well-baby Care	No Copay	40% ⁽²⁾
Diagnostic X-ray and Lab	20% ⁽²⁾	40% ⁽²⁾
Complex Diagnostics (MRI/CT Scan)	20% ⁽²⁾	40% ⁽²⁾ (limited to \$800 / test)
Chiropractic (30 visits / calendar year)	\$20 Copay / Visit	40% ⁽²⁾
Acupuncture (20 visits / calendar year)	\$20 Copay / Visit	40% ⁽²⁾
Therapy, including Physical, Occupational and Speech	20% ⁽²⁾	40% ⁽²⁾
Hospital Services		
Inpatient	20% ⁽²⁾	40% ⁽²⁾ (benefit limited to \$1,000 / day for non-emergency admission)
Outpatient Surgery	20% ⁽²⁾	40% ⁽²⁾ (benefit limited to \$350 / admit)
Emergency Room	\$150 Copay + 20% (Copay waived if admitted)	
Urgent Care	\$20 Copay / Visit	40% ⁽²⁾
Maternity Care		
Physician Services (prenatal or postnatal)	\$20 Copay / Visit	40% ⁽²⁾
Hospital Services	20% ⁽²⁾	40% ⁽²⁾ (benefit limited to \$1,000 / day for non-emergency admission)
Mental Health & Substance Abuse		
Inpatient	20% ⁽²⁾	40% ⁽²⁾ (benefit limited to \$1,000 / day for non-emergency admission)
Outpatient	\$20 Copay / Visit 20% ⁽²⁾ (Facility Care)	40% ⁽²⁾
Retail Prescription Drugs (30-day supply)		
Tier 1	\$10 Copay	Copay plus 50% of remaining maximum and costs in excess of allowed maximum up to \$250 per prescription for Retail Pharmacy
Tier 2	\$25 Copay	
Tier 3	\$40 Copay	
Tier 4	20% up to \$150 per Rx	
Mail Order Prescription Drugs (90-day supply)		
Tier 1	\$10 Copay	Not Covered
Tier 2	\$50 Copay	
Tier 3	\$80 Copay	
Tier 4 (30-day supply only)	20% up to \$150 per Rx	

⁽¹⁾ Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider

⁽²⁾ After Annual Deductible has been satisfied

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.