# Your summary of benefits

Anthem

Anthem® Blue Cross

Your Plan: Anthem Select HMO Classic 20/40/250 admit/125 OP

Your Network: Select HMO

| Visits with Virtual Care-Only Providers | Cost through our mobile app and website |
|---|---|
| **Primary Care, and medical services for urgent/acute care** | No charge |
| **Mental Health & Substance Use Disorder Services** | No charge |
| **Specialist care** | $40 copay per visit |

| Covered Medical Benefits | Cost if you use an In-Network Provider |
|---|---|
| **Overall Deductible** | $0 person |
| **Overall Out-of-Pocket Limit** | $2,000 single /<br>$4,000 family |
| To get benefits under this Plan, you must use In-Network Providers. **Services from Out-of-Network Providers are not covered**, except for Emergency or Urgent Care, Authorized Services, or when required by law. Please be sure to contact us if you are not sure if we have approved an Authorized Service.<br>The family out-of-pocket limit is embedded, meaning each covered person is capped at his or her per single out-of-pocket limit; in addition, cost shares for all covered family members apply to the family out-of-pocket limit, yet no one member will pay more than the per single out-of-pocket limit.<br>All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit. | |
| **Doctor Visits (virtual and office)** *Your plan requires the selection of a Primary Care Physician (PCP). A referral from your Primary Care Physician (PCP) is required for Specialist care and most other providers for select covered services.* | |
| **Primary Care (PCP)** *virtual and office* | $20 copay per visit |
| **Mental Health and Substance Use Disorder Services** *virtual and office* | $20 copay per visit |
| **Specialist Provider** *virtual and office* | $40 copay per visit |
| **Other Practitioner Visits** | |
| **Maternity Doctor services** | |
| Prenatal and Postpartum care | $20 copay per visit |
| Delivery | $250 copay per pregnancy |
| **Retail Health Clinic** *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.* | $20 copay per visit |
| **Manipulation Therapy**<br>*Coverage is limited to 20 visits per benefit period.* | $20 copay per visit |

| Covered Medical Benefits | Cost if you use an In-Network Provider |
|---|---|
| **Acupuncture**<br>*Coverage is limited to 20 visits per benefit period.* | $20 copay per visit |
| **Other Services in an Office** | |
| **Allergy Testing** | $20 copay per visit |
| **Prescription Drugs** *Dispensed in the office*<br>*Maximum of $250 member cost share per drug.* | 30% coinsurance |
| **Surgery** | $20 copay per surgery |
| **Preventive care / screenings / immunizations** | No charge |
| **Preventive Care for Chronic Conditions** *per IRS guidelines* | No charge |
| **Diagnostic Services Lab** | |
| Office | No charge |
| Freestanding Lab | No charge |
| Outpatient Hospital | No charge |
| **Diagnostic Services X-Ray** | |
| Office | No charge |
| Freestanding Radiology Center | No charge |
| Outpatient Hospital | No charge |
| **Diagnostic Services Advanced Diagnostic Imaging** *for example: MRI, PET and CAT scans* | |
| Office | $125 copay per day |
| Freestanding Radiology Center | $125 copay per day |
| Outpatient Hospital | $125 copay per day |
| **Emergency and Urgent Care** | |
| **Urgent Care** | **In-Network and Out-of-Network Providers:**<br>$20 copay per visit |
| **Emergency Room Facility Services**<br>*Your copay will be waived if admitted.* | **In-Network and Out-of-Network Providers:**<br>$200 copay per visit |
| **Emergency Room Doctor and Other Services** | **In-Network and Out-of-Network Providers:**<br>No charge |
| **Ambulance** | **In-Network and Out-of-Network Providers:**<br>$150 copay per trip |

| Covered Medical Benefits | Cost if you use an In-Network Provider |
|---|---|
| **Outpatient Mental Health and Substance Use Disorder Services at a Facility** | |
| **Facility Fees** | No charge |
| **Doctor Services** | No charge |
| **Outpatient Surgery** | |
| **Facility Fees** | |
| Hospital | $125 copay per visit |
| Ambulatory Surgical Center | $125 copay per visit |
| **Physician and other services** *including surgeon fees* | |
| Hospital | No charge |
| **Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)**<br>*If readmitted within 72 hours for the same condition, no additional facility copay is required. If transferred between facilities, only one copay will apply.* | |
| **Facility Fees** | $250 copay per admission |
| **Physician and other services** *including surgeon fees* | No charge |
| **Home Health Care**<br>*Coverage is limited to 100 visits per benefit period.* | $20 copay per visit |
| **Therapy Services** | |
| **Rehabilitation and Habilitation services** *including physical, occupational and speech therapies.*<br>*Coverage for physical and occupational therapies is limited to 40 visits combined per benefit period. Coverage for speech therapy is limited to 20 visits per benefit period.* | |
| Office | $20 copay per visit |
| Outpatient Hospital | $40 copay per visit |
| **Pulmonary rehabilitation** | |
| Office | $20 copay per visit |
| Outpatient Hospital | $40 copay per visit |
| **Cardiac rehabilitation**<br>*Coverage is limited to 36 visits per benefit period.* | |
| Office | $20 copay per visit |
| Outpatient Hospital | $40 copay per visit |
| **Dialysis/Hemodialysis** *office and outpatient hospital* | $40 copay per visit |

| Covered Medical Benefits | Cost if you use an In-Network Provider |
|---|---|
| | |
| **Chemo/Radiation Therapy** *office and outpatient hospital* | $40 copay per visit |
| **Skilled Nursing Care (facility)**<br>*Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.* | No charge |
| **Inpatient Hospice** | No charge |
| **Additional Services, Equipment and Devices**<br>**Durable Medical Equipment** | 20% coinsurance |
| **Prosthetic Devices** | No charge |
| **Wigs**<br>*Coverage for wigs is limited to 1 item after cancer treatment per benefit period.* | No charge |

| 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 covered |
| **Pharmacy Out-of-Pocket Limit** | Combined with In-Network medical out-of-pocket limit | Not covered |
| **Prescription Drug Coverage**<br>**Network:** ***Base Network***<br>**Drug List:** ***CA Essential DMHC*** *Drugs not included on the CA Essential DMHC drug list will not be covered.*<br>***For more information, refer to "CA Essential DMHC Drug List" at*** *https://www.anthem.com/ca/pharmacy-information/.* | | |
| **Day Supply Limits**<br>**Retail Pharmacy:** *30 day supply (cost shares noted below)*<br>**Retail 90 Pharmacy:** *90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).*<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 1a - Typically Lower Cost Generic** | $5 copay per prescription (retail) and $10 copay per prescription (home delivery) | Not covered (retail and home delivery) |
| **Tier 1b - Typically Generic** | $20 copay per prescription (retail) and | Not covered (retail and home delivery) |

| Covered Prescription Drug Benefits | Cost if you use an In-Network Pharmacy | Cost if you use an Out-of-Network Pharmacy |
|---|---|---|
| | $40 copay per prescription (home delivery) | |
| **Tier 2 - Typically Preferred Brand** | $40 copay per prescription (retail) and $100 copay per prescription (home delivery) | Not covered (retail and home delivery) |
| **Tier 3 - Typically Non-Preferred Brand** | $60 copay per prescription (retail) and $150 copay per prescription (home delivery) | Not covered (retail and home delivery) |
| **Tier 4 - Typically Specialty (brand and generic)** | 30% coinsurance up to $250 per prescription (retail and home delivery) | Not covered (retail and home delivery) |

| Covered Vision Benefits | Cost if you use an In-Network Provider | Cost if you use an Out-of-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 exam (up to age 19)**<br>*Limited to 1 exam per benefit period.* | No charge | Not covered |
| **Adult Vision exam (age 19 and older)**<br>*Limited to 1 exam per benefit period.* | No charge | Not covered |

**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.
- 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.
- Coverage includes the diagnosis and treatment of infertility and fertility services, including a maximum of three completed oocyte retrievals with unlimited embryo transfers in accordance with the guidelines of the American Society of Reproductive Medicine (ASRM). These services are provided on the same basis, at the same cost shares, as any other medical condition.

- 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.*

*Anthem Blue Cross HMO benefits are covered only when services are provided or coordinated by the primary care physician and authorized by the participating medical group or independent practice association (IPA); except OB/GYN services received within the member's medical group/IPA, and services for mental health and substance use disorders. Benefits are subject to all terms, conditions, limitations, and exclusions of the EOC.*

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Questions: (855) 333-5730 or visit us at www.anthem.com/ca

# Your summary of benefits

Anthem

Anthem® Blue Cross

Your Plan: Chiropractic-Manipulative Treatment Rider

Your Network: ASH

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|
| Benefits described in this section are provided through an agreement between Anthem Blue Cross and American Specialty Health Plans of California, Inc. (ASH Plans). The services described in this section are covered only if provided by a chiropractor that is an In-Network Provider. These benefits are in addition to the benefits described in the "Therapy Services" provision within the Evidence of Coverage (EOC). However, when you are treated by a chiropractor that is an In-Network Provider, services will not be covered other than those benefits specifically described in this section. You may search for chiropractors that are In-Network Providers using the "Find Care" function on our website at www.anthem.com/ca and select the HMO Chiropractic/Acupuncture Network (American Specialty Health Plans). | | |
| **Your First Visit** You must make an appointment with a chiropractor that is an In-Network Provider for an examination of your condition. You do not need a referral from your Medical Group or Primary Care Physician to see a chiropractor that is an In-Network Provider.<br>**Services Must be Approved** All services must be approved as Medically Necessary except for:<br>• An initial new patient exam by a chiropractor that are In-Network Provider and the provision or commencement, during the initial new patient exam, of Medical Necessary services that are chiropractic services, to the extent services are consistent with professionally recognized, valid, evidence-based standards of practice; and<br>• Emergency Services.<br>If additional services are required after the initial new patient exam and they are approved as Medically Necessary, you are covered up to the maximum number of visits shown below. All visits will be applied towards the maximum number of visits in a Benefit Period.<br>**Services Not Approved** A chiropractor that is an In-Network Provider may provide non-Covered Services. However, you must agree in writing, before receiving non-Covered Services, to pay for them yourself. If a chiropractor that is an In-Network Provider provides non-Covered Services without obtaining your written acknowledgement prior to providing the non-Covered Services, you will not be financially responsible to pay the provider for such non-Covered Services. | | |
| **Visits in an Office & Outpatient**<br>**Chiropractic Care**<br>*Coverage is limited to 30 visits per benefit period. Benefit limit is for office and outpatient combined.* | $10 copay per visit | Not covered |
| **Diagnostic Services**<br>**Lab**<br>**Chiropractic labs**<br>*Covered when prescribed by a chiropractor that is an In-Network Provider and approved as Medically Necessary.* | Covered at the same cost share percentage as Diagnostic Labs. | Not covered |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|
| **Chiropractic X-Ray**<br>*Covered when prescribed by a chiropractor that is an In-Network Provider and approved as Medically Necessary.* | Covered at the same cost share percentage as Diagnostic X-ray. | Not covered |
| **Durable Medical Equipment**<br><br>**Chiropractic appliances**<br>*Covered when prescribed by a chiropractor that is an In-Network Provider and approved as Medically Necessary.* | $50 maximum of Chiropractic Appliances per Benefit Period. | Not covered |

*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.*

*Anthem Blue Cross HMO benefits are covered only when services are provided or coordinated by the primary care physician and authorized by the participating medical group or independent practice association (IPA); except OB/GYN services received within the member's medical group/IPA, and services for mental health and substance use disorders. Benefits are subject to all terms, conditions, limitations, and exclusions of the EOC.*

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 with translations or interpreter services, in a timely manner, please call the telephone number on the back of your ID card. (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 es así, podemos pedirle a alguien que lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda oportuna y gratuita con traducciones o servicios de interpretación, llame al número de teléfono que figura en el dorso de su tarjeta de identificación. (TTY/TDD: 711).

**Arabic**
هام: هل يمكنك قراءة هذه الرسالة؟ إذا لم يكن الأمر كذلك، فيمكننا أن نطلب من شخص ما مساعدتك في قراءتها. قد تتمكن أيضا من الحصول على هذه الرسالة مكتوبة بلغتك. للحصول على مساعدة مجانية في خدمات الترجمة أو الترجمة الفورية، في الوقت المناسب، يرجى الاتصال برقم الهاتف الموجود على ظهر بطاقة الهوية الخاصة بك. (TTY/TDD:711).

**Armenian**
ԿԱՐԵՎՈՐ Է. կարողանո՞ւմ եք կարդալ այս նամակը: Եթե ոչ, կարող ենք օգնել ձեզ կարդալ այն: Դուք կարող եք նաև ստանալ այս նամակը գրավոր՝ ձեր լեզվով: Թարգմանությունների կամ թարգմանչական ծառայությունների անվճար օգնության համար, ժամանակին, խնդրում ենք զանգահարել ձեր ID քարտի հակառակ կողմում նշված հեռախոսահամարով: (TTY/TDD՝ 711):

**Chinese**
重要提示：您能讀懂這封信嗎？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。如需及時獲得免費的翻譯或口譯服務協助，請撥打您 ID 卡背面的電話號碼。(TTY/TDD:711)。

**Farsi**
مهم: می‌توانید این نامه را بخوانید؟ اگر نه، می‌توانیم از کسی بخواهیم که در خواندن آن به شما کمک کند. همچنین ممکن است بتوانید این نامه را به زبان خودتان دریافت کنید. برای دریافت کمک رایگان و به‌موقع در زمینه خدمات ترجمه کتبی یا مترجم شفاهی، لطفاً با شماره تلفن مندرج در پشت کارت ID خود تماس بگیرید. (TTY/TDD:711).

**Hindi**
महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? यदि नहीं, तो हम किसी को इसे पढ़ने में आपकी सहायता करने के लिए रख सकते हैं। आप इस पत्र को अपनी भाषा में भी लिखवा सकते हैं। अनुवाद या दुभाषिया सेवाओं के संबंध में समय पर निःशुल्क सहायता के लिए कृपया अपने पहचान पत्र के पीछे दिए गए टेलीफोन नंबर पर कॉल करें। (TTY/TDD:711)।

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**Hmong**
TSEEM CEEB: Koj puas yeem nyeem tau tsab ntawv no? Yog tias nyeem tsis tau, peb mam kom lwm tus neeg los pab nyeem rau koj. Koj hais tau kom muab tsab ntawv no sau ua koj yam lus. Rau kev pab txhais ntawv los sis txhais lus pab dawb, kom raws sij hawm, thov hu tus npawb xov tooj nyob sab nraum qab ntawm koj daim npav ID. (TTY/TDD: 711).

**Japanese**
重要：この手紙は読めますか？そうでない場合は、誰かに読んでもらうのを手伝ってもらうこともできます。このお知らせは、貴方の言語で受け取ることも可能です。翻訳や通訳サービスの無料サポートをご希望の場合は、ID カードの裏面に記載されている電話番号までお電話ください。(TTY/TDD:711)。

**Khmer**
សំខាន់៖ តើអ្នកអាចអានសំបុត្រនេះបានទេ? បើអត់ទេ យើងអាចមានអ្នកជួយអ្នកឱ្យអានវាបាន។ អ្នកកាប្រហែលជាអាចឱ្យសំបុត្រនេះសរសេរជាភាសារបស់អ្នកបានផងដែរ។ ដើម្បីទទួលបានជំនួយដោយឥតគិតថ្លៃជាមួយនឹងការបកប្រែឬសេវាអ្នកបកប្រែផ្ទាល់មាត់ទាន់ពេលវេលា សូមទូរស័ព្ទទៅលេខនៅខាងក្រោយកាត ID របស់អ្នក។ (TTY/TDD:711)។

**Korean**
중요: 이 서신을 읽으실 수 있습니까? 그렇지 않다면 서신을 읽을 수 있게 도움을 드릴 수 있습니다. 원하시는 언어로 이 서신을 받으실 수도 있습니다. 번역이나 통역 서비스를 무료로 이용하시려면 적시에 ID 카드 뒷면에 있는 전화번호로 전화해 주십시오. (TTY/TDD: 711).

**Punjabi**
ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵੀ ਲਿਖਵਾ ਸਕਦੇ ਹੋ। ਅਨੁਵਾਦ ਜਾਂ ਦੁਭਾਸ਼ੀਏ ਸੇਵਾਵਾਂ ਵਿੱਚ ਮੁਫ਼ਤ ਮਦਦ ਲਈ, ਸਮੇਂ ਸਿਰ, ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਟੈਲੀਫੋਨ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ। (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. Чтобы своевременно получить бесплатные услуги письменного или устного перевода, позвоните по номеру телефона, указанному на оборотной стороне вашей идентификационной карты участника. (TTY/TDD: 711).

**Tagalog**
MAHALAGA: Nababasa mo ba ang sulat na ito? Kung hindi, maaari kaming kumuha ng taong tutulong sa iyo na basahin ito. Maaari mo ring ipasulat ang sulat na ito sa iyong wika. Para sa libreng tulong sa mga pagsasalin o serbisyo ng interpreter, sa isang napapanahong paraan, mangyaring tawagan ang numero ng telepono sa likod ng iyong ID card. (TTY/TDD:711).

**Thai**
ข้อสำคัญ: คุณสามารถอ่านจดหมายฉบับนี้ได้หรือไม่ ถ้าไม่ เราสามารถหาคนช่วยอ่านให้กับคุณได้ นอกจากนี้คุณยังสามารถขอให้เขียนจดหมายให้ได้ในภาษาของคุณเอง ขอรับบริการแปลหรือล่ามที่รวดเร็วได้ฟรี กรุณาติดต่อหมายเลขโทรศัพท์ที่ด้านหลังของบัตรประจำตัวของคุณ (TTY/TDD:711).

**Vietnamese**
QUAN TRỌNG: Quý vị có thể đọc lá thư này không? Nếu không, chúng tôi có thể nhờ ai đó giúp quý vị đọc thư. Quý vị cũng có thể yêu cầu viết lá thư này bằng ngôn ngữ của mình. Để được trợ giúp miễn phí về dịch vụ biên dịch hoặc thông dịch một cách kịp thời, vui lòng gọi số điện thoại ở mặt sau thẻ ID của quý vị. (TTY/TDD: 711).

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