Your summary of benefits

Anthem® Blue Cross

Your Plan: Anthem CaliforniaCare HMO Value Ded 750/25/40/25%

Your Network: California Care 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 medical deductible does not apply
Mental Health & Substance Use Disorder Services	No charge medical deductible does not apply
Specialist care	$40 copay per visit medical deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider
Overall Deductible	$750 person / $1,500 family
Overall Out-of-Pocket Limit	$3,500 single / $7,000 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. The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per single out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per single out-of-pocket limit. 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) and Mental Health and Substance Use Disorder Services *virtual and office* **Specialist Provider** *virtual and office*	$25 copay per visit medical deductible does not apply $40 copay per visit medical deductible does not apply
<u>**Other Practitioner Visits**</u> **Maternity services** Prenatal and Postpartum care Delivery **Retail Health Clinic** *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	 $25 copay per visit medical deductible does not apply 25% coinsurance after medical deductible is met $25 copay per visit medical deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider
Manipulation Therapy *Coverage is limited to 20 visits per benefit period.*	$25 copay per visit medical deductible does not apply
Acupuncture *Coverage is limited to 20 visits per benefit period.*	$25 copay per visit medical deductible does not apply
Other Services in an Office	
Allergy Testing	$25 copay per visit medical deductible does not apply
Prescription Drugs *Dispensed in the office* *Maximum of $250 member cost share per drug.*	30% coinsurance medical deductible does not apply
Surgery	$25 copay per surgery medical deductible does not apply
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	25% coinsurance after medical deductible is met
Diagnostic Services X-Ray	
Office	No charge
Freestanding Radiology Center	No charge
Outpatient Hospital	25% coinsurance after medical deductible is met
Diagnostic Services Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*	
Office	$125 copay per day medical deductible does not apply
Freestanding Radiology Center	$125 copay per day medical deductible does not apply
Outpatient Hospital	$125 copay per day medical deductible does not apply
Emergency and Urgent Care	
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	**In-Network and Out-of-Network Providers:** $25 copay per visit medical deductible does not apply
Emergency Room Facility Services *Your copay will be waived if admitted.*	**In-Network and Out-of-Network Providers:** $200 copay per visit and 25% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider
Emergency Room Doctor and Other Services **Ambulance**	**In-Network and Out-of-Network Providers:** No charge **In-Network and Out-of-Network Providers:** $150 copay per trip medical deductible does not apply
<u>Outpatient Mental Health and Substance Use Disorder Services at a Facility</u> **Facility Fees** **Doctor Services**	 No charge No charge
<u>Outpatient Surgery</u> **Facility Fees** Hospital Ambulatory Surgical Center **Physician and other services** *including surgeon fees* Hospital	 25% coinsurance after medical deductible is met 25% coinsurance after medical deductible is met No charge
<u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u> **Facility Fees** **Physician and other services** *including surgeon fees*	 25% coinsurance after medical deductible is met No charge
<u>Home Health Care</u> *Coverage is limited to 100 visits per benefit period.*	$25 copay per visit medical deductible does not apply
<u>Therapy Services</u> **Rehabilitation and Habilitation services** *including physical, occupational and speech therapies.* *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 Outpatient Hospital	 $25 copay per visit medical deductible does not apply 25% coinsurance after medical deductible is met
Pulmonary rehabilitation Office Outpatient Hospital	 $25 copay per visit medical deductible does not apply 25% coinsurance after medical deductible is met
Cardiac rehabilitation *Coverage is limited to 36 visits per benefit period.*	

Covered Medical Benefits	Cost if you use an In-Network Provider
Office Outpatient Hospital	$25 copay per visit medical deductible does not apply 25% coinsurance after medical deductible is met
Dialysis/Hemodialysis Office Outpatient Hospital	 $40 copay per visit medical deductible does not apply 25% coinsurance after medical deductible is met
Chemo/Radiation Therapy Office Outpatient Hospital	 $40 copay per visit medical deductible does not apply 25% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.*	25% coinsurance after medical deductible is met
Inpatient Hospice	No charge
<u>Additional Services, Equipment and Devices</u> **Durable Medical Equipment**	 20% coinsurance medical deductible does not apply
Prosthetic Devices	No charge
Wigs *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 **Network:** ***Base Network*** **Drug List:** ***CA Essential DMHC*** *Drugs not included on the CA Essential DMHC drug list will not be covered.*		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).* **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.*		

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
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 $40 copay per prescription (home delivery)	Not covered (retail and home delivery)
Tier 2 - Typically Preferred Brand	$50 copay per prescription (retail) and $125 copay per prescription (home delivery)	Not covered (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand	$75 copay per prescription (retail) and $188 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) *Limited to 1 exam per benefit period.*	No charge	Not covered
Adult Vision exam (age 19 and older) *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.
- 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.

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

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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, please call right away at 1-888-254-2721. (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, podemos pedirle a alguien que le ayude a leerla. También es posible que pueda solicitar que le enviemos esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721 (TTY/TDD: 711).

Arabic

هام: هل تستطيع قراءة هذه الرسالة؟ إذا لم يكن الأمر كذلك، يمكننا أن نطلب من شخص ما مساعدتك في قراءتها. قد تتمكن أيضًا من الحصول على هذه الرسالة مكتوبة بلغتك. للحصول على مساعدة مجانية، يرجى الاتصال على الفور على الرقم
1-888-254-2721. (TTY/TDD: 711)

Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք կարդալ այս նամակը: Եթե ոչ, մենք կարող ենք առաջարկել որևէ մեկի օգնությունը՝ ձեզ համար այն կարդալու համար: Դուք կարող եք նաև այս նամակը ստանալ ձեր լեզվով: Անվճար օգնության համար խնդրում ենք անմիջապես զանգահարել՝ 1-888-254-2721. (TTY/TDD: 711)

Chinese

重要：您能看此信嗎？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。如需免費幫助，請立即致電 1-888-254-2721. (TTY/TDD:711)

Farsi

ما ،توانیدنمی اگر بخوانید؟ را نامه این توانید می آیا :مهم
.کند کمک شما به آن خواندن در بخواهیم شخصی از توانیم‌می
زبان به و کتبی صورت به را نامه این بتوانید است ممکن همچنین
با فوراً لطفاً ،رایگان کمک دریافت برای .کنید دریافت خودتان
تماس 1-888-254-2721. (TTY/TDD: 711) شماره
.بگیرید

Hindi

महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में किसी की मदद ले सकते हैं। यह पत्र आप अपनी भाषा में भी लिखवा सकते हैं। निःशुल्क सहायता के लिए, कृपया तुरंत 1-888-254-2721 पर कॉल करें। (टीटीवाई/टीडीडी:711)

Hmong

TSEEM CEEB: Koj puas nyeem tau daim ntawv no? Yog tias tsis tau, peb muaj qee tus neeg pab nyeem nws rau koj. Koj los kuj yuav tau txais ib daim ntawv sau ua kom yam lus. Rau kev pab dawb, thov hu tam sim ntawm 1-888-254-2721. (TTY/TDD: 711)

Japanese

重要：この文書を読むことができますか？読むことができない場合、支援することが可能です。また、日本語で訳されたこの文書を書面で受け取ることができます。無料の支援をご希望の場合、1-888-254-2721（TTY/TDD:711）にご連絡ください。

Khmner

សំខាន់៖ តើអ្នកអាចអានសំបុត្រនេះបានទេ? បើអត់ទេ យើងអាចមានអ្នកជួយអាន។ អ្នកក៏អាចទទួលបានសំបុត្រនេះសរសេរជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមទូរស័ព្ទមកភ្លាមៗតាមរយៈលេខ 1-888-254-2721. (TTY/TDD: 711)

Korean

중요: 이 편지를 읽으실 수 있으신가요? 그렇지 않으신 경우, 이를 읽으실 수 있도록 도움을 제공해 드릴 수 있습니다. 귀하의 모국어로 된 편지를 우편으로 받아보실 수도 있습니다. 무상으로 제공되는 도움이 필요하신 경우, 1-888-254-2721번으로 바로 연락해 주십시오. (TTY/TDD: 711)

Punjabi

ਕੀ ਤੁਸੀ ਇਹ ਚਿੱਠੀ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀ, ਤਾਂ ਅਸੀ ਇਸਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਸ ਚਿੱਠੀ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵੀ ਲਿਖ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮਦਦ ਲਈਂ, ਕਿਰਪਾ ਕਰਕੇ ਤੁਰੰਤ ਇਸ 'ਤੇ ਕਾਲ ਕਰੋ 1-888-254-2721। (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. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

Tagalog

MAHALAGA: Mababasa mo ba ang sulat na ito? Kung hindi, mayroon kaming makakatulong sa iyo na basahin ito. Maaari mo ring makuha ang sulat na ito nang nakasulat sa iyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai

สำคัญ: คุณสามารถอ่านจดหมายนี้ได้หรือไม่ หากคุณอ่านจดหมายนี้ไม่ได้ เราสามารถขอให้ใครสักคนช่วยคุณอ่านได้ คุณสามารถร้องขอจดหมายนี้ที่เขียนในภาษาของคุณได้เช่นกัน หากต้องการความช่วยเหลือแบบไม่มีค่าใช้จ่าย โปรดโทรหาเราได้ทันทีที่ 1-888-254-2721. (TTY/TDD: 711)

Vietnamese

QUAN TRỌNG: Quý vị có đọc được lá thư này không? Nếu không, chúng tôi có thể nhờ ai đó giúp quý vị đọc. Quý vị cũng có thể yêu cầu thư này viết bằng ngôn ngữ của quý vị. Để được trợ giúp miễn phí, hãy gọi ngay đến số 1-888-254-2721. (TTY/TDD: 711)

It’s important we treat you fairly

We follow state and federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don’t discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. For people whose primary language isn’t English (or have limited proficiency), we offer free language assistance services, in a timely manner, like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or if you think you were discriminated against based on race, color, national origin, age, disability, or sex, you can mail a complaint directly to 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. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf