Your summary of benefits

ACWA JPIA – C00361

Anthem® Blue Cross

Your Plan: 2027 HMO Value Plan (0KGJ)

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
Mental Health & Substance Use Disorder Services	No charge
Specialist care	$30 copay per visit

Covered Medical Benefits	Cost if you use an In-Network Provider
Overall Deductible *Your plan applies a separate Pharmacy Deductible to prescription drugs obtained at a pharmacy. See the Covered Prescription Drug Benefits section.*	$0 person
Overall Out-of-Pocket Limit *The out-of-pocket costs you pay for prescription drugs obtained at a pharmacy will apply to a separate Pharmacy Out-of-Pocket Limit. See the Covered Prescription Drug Benefits section.*	$2,500 single / $5,000 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 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. All medical copayments and coinsurance apply to the medical 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*	$30 copay per visit
Mental Health and Substance Use Disorder Services *virtual and office*	$30 copay per visit
Specialist Provider *virtual and office*	$30 copay per visit
Other Practitioner Visits	
Maternity Doctor services	
Prenatal and Postpartum care	$30 copay per visit
Delivery	No charge
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$30 copay per visit

Covered Medical Benefits	Cost if you use an In-Network Provider
Manipulation Therapy (Chiropractic Services) Coverage for rehabilitative and habilitative physical therapy, occupational therapy, speech therapy, and manipulative treatment is limited to 60 visits combined per benefit period.	$30 copay per visit
Manipulation Therapy via ASH plan provider *Coverage is limited to 30 visits per year. Benefit limit is for office and outpatient combined.*	$10 copay per visit
Acupuncture	$30 copay per visit
Other Services in an Office	
Allergy Testing	$30 copay per visit
Prescription Drugs *Dispensed in the office* *Maximum of $150 member cost share per drug.*	30% coinsurance
Surgery	$30 copay per visit
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	$100 copay per service
Freestanding Radiology Center	$100 copay per service
Outpatient Hospital	$100 copay per service

Covered Medical Benefits	Cost if you use an In-Network Provider
Emergency and Urgent Care	
Urgent Care	**In-Network and Out-of-Network Providers:** $30 copay per visit
Emergency Room Facility Services *Your copay will be waived if admitted.*	**In-Network and Out-of-Network Providers:** $150 copay per visit
Emergency Room Doctor and Other Services	**In-Network and Out-of-Network Providers:** No charge
Ambulance	**In-Network and Out-of-Network Providers:** $50 copay per trip
Outpatient Mental Health and Substance Use Disorder Services at a Facility	
Facility Fees	No charge
Doctor Services	No charge
Outpatient Surgery	
Facility Fees	
Hospital	No charge
Ambulatory Surgical Center	No charge
Physician and other services *including surgeon fees*	
Hospital	No charge
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services) *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 *Coverage is limited to 100 visits per benefit period.*	$30 copay per visit
Therapy Services	
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for physical, occupational and speech therapies and manipulative treatment is limited to 60 visits combined per benefit period.*	
Office	$30 copay per visit
Outpatient Hospital	$30 copay per visit
Pulmonary rehabilitation *office and outpatient hospital*	$30 copay per visit

Covered Medical Benefits	Cost if you use an In-Network Provider
Cardiac rehabilitation *office and outpatient hospital*	$30 copay per visit
Dialysis/Hemodialysis Office Outpatient Hospital	 $30 copay per visit No charge
Chemo/Radiation Therapy Office Outpatient Hospital	 $30 copay per visit No charge
Skilled Nursing Care (facility) *Coverage is limited to 100 days per benefit period.*	No charge
Inpatient Hospice	No charge
Additional Services, Equipment and Devices **Durable Medical Equipment**	 No charge
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	$100 person / $300 family	Not covered
Pharmacy Out-of-Pocket Limit	$4,100 person / $8,200 family	Not covered

Prescription Drug Coverage
Network: ***Base Network***
Drug List: ***CA National DMHC*** *If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.*
For more information, refer to "CA National DMHC Drug List" at https://www.anthem.com/ca/pharmacy-information/.

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.*
Specialty Pharmacy: *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain*

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.		
Tier 1 - Typically Generic	$5 copay per prescription after Pharmacy deductible is met (retail) and $10 copay per prescription after Pharmacy deductible is met (home delivery)	Not covered
Tier 2 - Typically Preferred Brand	$20 copay per prescription after Pharmacy deductible is met (retail) and $40 copay per prescription after Pharmacy deductible is met (home delivery)	Not covered
Tier 3 - Typically Non-Preferred Brand	$50 copay per prescription after Pharmacy deductible is met (retail) and $100 copay per prescription after Pharmacy deductible is met (home delivery)	Not covered
Tier 4 - Typically Specialty (brand and generic) ***Self-Administered Injectable Drugs*** *(except insulin) Covers up to a 30 day supply (retail pharmacy) and up to 90 day supply (home delivery)* ***Specialty Pharmacy Program*** *- Certain specialty pharmacy drugs may be obtained through the specialty pharmacy program. Limited to a 30-day supply. Please contact the customer service number on the back of your ID card to see if your drug is on the specialty pharmacy program or obtain a list at anthem.com/ca.*	20% coinsurance up to $100 per prescription after Pharmacy deductible is met (retail) and 20% coinsurance up to $200 per prescription after Pharmacy deductible is met (home delivery) Applicable copay applies	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.

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. **Services Must be Approved** All services must be approved as Medically Necessary except for: • 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 • Emergency Services. 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. **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 **Chiropractic Care** *Coverage is limited to 30 visits per year. Benefit limit is for office and outpatient combined.*	$10 copay per visit	Not covered
Diagnostic Services **Lab** **Chiropractic labs** *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 *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		
Chiropractic appliances *Covered when prescribed by a chiropractor that is an In-Network Provider and approved as Medically Necessary.*	$50 maximum of Chiropractic Appliances per year.	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.

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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)।

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។ អ្នកក៏ប្រហែលជាអាចឱ្យសំបុត្រនេះសរសេរជាភាសារបស់អ្នកបានផងដែរ។ 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 ਟੈਲੀਫ਼ੋਨ 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).

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