# Your summary of benefits

Anthem® Blue Cross

Your Plan: PRISM – CSURMA: Custom Premier HMO 20/200 admit/100 OP

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** | $20 copay per visit |
| **Mental Health & Substance Use Disorder Services** | $20 copay per visit |
| **Specialist care** | $20 copay per visit |

| Covered Medical Benefits | Cost if you use an In-Network Provider |
|---|---|
| **Overall Deductible** | $0 person |
| **Overall Out-of-Pocket Limit** | $1,500 person /<br>$3,000 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 person 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 person out-of-pocket limit.<br>All medical 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* | $20 copay per visit |
| **Other Practitioner Visits** | |
| **Maternity Doctor services** | |
| Prenatal and Postpartum care | $20 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.* | $20 copay per visit |
| **Manipulation Therapy** | $20 copay per visit |

| Covered Medical Benefits | Cost if you use an In-Network Provider |
|---|---|
| *Coverage for rehabilitative and habilitative physical therapy, occupational therapy, speech therapy, and manipulative treatment is limited to 60 visits combined per benefit period.* | |
| **Acupuncture** | $20 copay per visit |
| **Other Services in an Office** | |
| **Allergy Testing** | $20 copay per visit |
| **Prescription Drugs** *Dispensed in the office*<br>*Maximum of $150 member cost share per drug.* | 20% coinsurance |
| **Surgery** | $20 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 |
| **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:**<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>$100 copay per visit |

| Covered Medical Benefits | Cost if you use an In-Network Provider |
|---|---|
| **Emergency Room Doctor and Other Services** | **In-Network and Out-of-Network Providers:** No charge |
| **Ambulance** | **In-Network and Out-of-Network Providers:** $100 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 | $100 copay per visit |
| Ambulatory Surgical Center | $100 copay per visit |
| **Physician and other services** *including surgeon fees* | |
| Hospital | No charge |
| **Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)** | |
| **Facility Fees** | $200 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, occupational and speech therapies and manipulative treatment is limited to 60 visits combined per benefit period.* | |
| Office | $20 copay per visit |
| Outpatient Hospital | $20 copay per visit |
| **Pulmonary rehabilitation** *office and outpatient hospital* | $20 copay per visit |
| **Cardiac rehabilitation** *office and outpatient hospital* | $20 copay per visit |
| **Dialysis/Hemodialysis** *office and outpatient hospital* | $20 copay per visit |
| **Chemo/Radiation Therapy** *office and outpatient hospital* | $20 copay per visit |

| Covered Medical Benefits | Cost if you use an In-Network Provider |
|---|---|
| **Skilled Nursing Care (facility)**<br>*Coverage is limited to 100 days per benefit period.* | No charge |
| **Inpatient Hospice** | No charge |
| **Additional Services, Equipment and Devices** | |
| **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 covered | Not covered |
| **Pharmacy Out-of-Pocket Limit** | Not covered | Not covered |
| **Prescription Drug Coverage**<br>**Network:**<br>**Drug List:** | | |
| **Day Supply Limits** | | |
| **Tier 1 - Typically Generic** | Not covered (retail and home delivery) | Not covered (retail and home delivery) |
| **Tier 2 - Typically Preferred Brand** | Not covered (retail and home delivery) | Not covered (retail and home delivery) |
| **Tier 3 - Typically Non-Preferred Brand** | Not covered (retail and home delivery) | Not covered (retail and home delivery) |
| **Tier 4 - Typically Specialty (brand and generic)** | Not covered (retail and home delivery) | Not covered (retail and home delivery) |

**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.*

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

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 أيضاً 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. կարողանա՞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។ 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).

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**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

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