

# 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 single / \$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.

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 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.

<b>Primary Care (PCP) and Mental Health and Substance Use Disorder Services</b> <i>virtual and office</i>	\$20 copay per visit
<b>Specialist Provider</b> <i>virtual and office</i>	\$20 copay per visit
<b><u>Other Practitioner Visits</u></b>	
<b>Maternity services</b>	
Prenatal and Postpartum care	\$20 copay per visit
Delivery	No charge
<b>Retail Health Clinic</b> <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i>	\$20 copay per visit
<b>Manipulation Therapy</b>	\$20 copay per visit

Covered Medical Benefits	Cost if you use an In-Network Provider
<p><i>Coverage for rehabilitative and habilitative physical therapy, occupational therapy, speech therapy, and manipulative treatment is limited to 60 visits combined per benefit period.</i></p> <p><b>Acupuncture</b></p>	\$20 copay per visit
<p><b><u>Other Services in an Office</u></b></p> <p><b>Allergy Testing</b></p> <p><b>Prescription Drugs</b> <i>Dispensed in the office</i> <i>Maximum of \$150 member cost share per drug.</i></p> <p><b>Surgery</b></p>	<p>\$20 copay per visit</p> <p>20% coinsurance</p> <p>\$20 copay per visit</p>
<b>Preventive care / screenings / immunizations</b>	No charge
<b>Preventive Care for Chronic Conditions</b> <i>per IRS guidelines</i>	No charge
<p><b><u>Diagnostic Services Lab</u></b></p> <p>Office</p> <p>Freestanding Lab</p> <p>Outpatient Hospital</p>	<p>No charge</p> <p>No charge</p> <p>No charge</p>
<p><b><u>Diagnostic Services X-Ray</u></b></p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>No charge</p> <p>No charge</p> <p>No charge</p>
<p><b><u>Diagnostic Services Advanced Diagnostic Imaging</u></b> <i>for example: MRI, PET and CAT scans</i></p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>\$100 copay per service</p> <p>\$100 copay per service</p> <p>\$100 copay per service</p>
<p><b><u>Emergency and Urgent Care</u></b></p> <p><b>Urgent Care</b> <i>includes doctor services. Your copay will be waived if admitted. Additional charges may apply depending on the care provided.</i></p> <p><b>Emergency Room Facility Services</b> <i>Your copay will be waived if admitted.</i></p>	<p><b>In-Network and Out-of-Network Providers:</b> \$20 copay per visit</p> <p><b>In-Network and Out-of-Network Providers:</b> \$100 copay per visit</p>

Covered Medical Benefits	Cost if you use an In-Network Provider
<b>Emergency Room Doctor and Other Services</b>	<b>In-Network and Out-of-Network Providers:</b> No charge
<b>Ambulance</b>	<b>In-Network and Out-of-Network Providers:</b> \$100 copay per trip
<b><u>Outpatient Mental Health and Substance Use Disorder Services at a Facility</u></b>	
<b>Facility Fees</b>	No charge
<b>Doctor Services</b>	No charge
<b><u>Outpatient Surgery</u></b>	
<b>Facility Fees</b>	
Hospital	\$100 copay per visit
Ambulatory Surgical Center	\$100 copay per visit
<b>Physician and other services</b> <i>including surgeon fees</i>	
Hospital	No charge
<b><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u></b>	
<b>Facility Fees</b>	\$200 copay per admission
<b>Physician and other services</b> <i>including surgeon fees</i>	No charge
<b><u>Home Health Care</u></b> <i>Coverage is limited to 100 visits per benefit period.</i>	\$20 copay per visit
<b><u>Therapy Services</u></b> <b>Rehabilitation and Habilitation services</b> <i>including physical, occupational and speech therapies.</i> <i>Coverage for physical, occupational and speech therapies and manipulative treatment is limited to 60 visits combined per benefit period.</i>	
Office	\$20 copay per visit
Outpatient Hospital	\$20 copay per visit
<b>Pulmonary rehabilitation</b> <i>office and outpatient hospital</i>	\$20 copay per visit
<b>Cardiac rehabilitation</b> <i>office and outpatient hospital</i>	\$20 copay per visit
<b>Dialysis/Hemodialysis</b> <i>office and outpatient hospital</i>	\$20 copay per visit
<b>Chemo/Radiation Therapy</b> <i>office and outpatient hospital</i>	\$20 copay per visit
<b>Skilled Nursing Care (facility)</b> <i>Coverage is limited to 100 days per benefit period.</i>	No charge

Covered Medical Benefits	Cost if you use an In-Network Provider
Inpatient Hospice	No charge
<b><u>Additional Services, Equipment and Devices</u></b>	
Durable Medical Equipment	20% coinsurance
Prosthetic Devices	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
<b>Prescription Drug Coverage Network:</b> <b>Drug List:</b>		
<b>Day Supply Limits:</b>		
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](http://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 أيضاً 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، توانیدمی اگر بخوانید؟ را نامه این توانید می آيا: 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 (TTY/TDD: 711) 1-888-254-2721. 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។ អ្នកក៏អាចទទួលបានសំបុត្រនេះសរសេរជាភាសា របស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយ ឥតគិតថ្លៃ 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 ਤੁਸੀਂ ਇਹ ਚਿੱਠੀ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ  
ਇਸਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ  
ਇਸ ਚਿੱਠੀ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵੀ ਲਿਖ ਸਕਦੇ ਹੋ।  
ਮੁਫਤ ਮਦਦ ਲਈ, 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 เราสามารถขอให้  
ใครสักคนช่วยคุณอ่านได้ คุณสามารถร้องขอ  
จดหมายนี้ที่เขียนในภาษาของคุณได้เช่นกัน  
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>