

# Your summary of benefits



Anthem® Blue Cross

Your Plan: City of Fontana: Modified Classic HMO 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	\$10 copay per visit
Mental Health & Substance Use Disorder Services	\$10 copay per visit
Specialist care	\$30 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 / \$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.

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 and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit.

<b>Doctor Visits (virtual and office)</b> 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	\$15 copay per visit
Specialist Provider virtual and office	\$30 copay per visit
<b>Other Practitioner Visits</b>	
Maternity services	
Prenatal and Postpartum care	\$15 copay per visit
Delivery	\$250 copay per visit
Retail Health Clinic for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.	\$15 copay per visit
Manipulation Therapy	\$15 copay per visit

Covered Medical Benefits	Cost if you use an In-Network Provider
<b>Acupuncture</b>	\$15 copay per visit
<b><u>Other Services in an Office</u></b>	
Allergy Testing	\$15 copay per visit
<b>Prescription Drugs</b> <i>Dispensed in the office</i> <i>Maximum of \$250 member cost share per drug.</i>	30% coinsurance
<b>Surgery</b>	No charge
<b>Preventive care / screenings / immunizations</b>	No charge
<b>Preventive Care for Chronic Conditions</b> <i>per IRS guidelines</i>	No charge
<b><u>Diagnostic Services</u> Lab</b>	
Office	No charge
Freestanding Lab	No charge
Outpatient Hospital	No charge
<b><u>Diagnostic Services</u> X-Ray</b>	
Office	No charge
Freestanding Radiology Center	No charge
Outpatient Hospital	No charge
<b><u>Diagnostic Services</u> Advanced Diagnostic Imaging</b> <i>for example: MRI, PET and CAT scans</i>	
Office	\$100 copay per service
Freestanding Radiology Center	\$100 copay per service
Outpatient Hospital	\$100 copay per service
<b><u>Emergency and Urgent Care</u></b>	
<b>Urgent Care</b> <i>includes doctor services. Additional charges may apply depending on the care provided.</i>	<b>In-Network and Out-of-Network Providers:</b> \$15 copay per visit
<b>Emergency Room Facility Services</b>	
<i>Your copay will be waived if admitted.</i>	<b>In-Network and Out-of-Network Providers:</b> \$125 copay per visit
<b>Emergency Room Doctor and Other Services</b>	
<b>Ambulance</b>	<b>In-Network and Out-of-Network Providers:</b> No charge

Covered Medical Benefits	Cost if you use an In-Network Provider
<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	\$125 copay per visit
Ambulatory Surgical Center	\$125 copay per visit
<b>Physician and other services including surgeon fees</b>	
Hospital	No charge
<b><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u></b>	
<i>If readmitted within 72 hours for the same condition, no additional facility copay is required. If transferred between facilities, only one copay will apply.</i>	
<b>Facility Fees</b>	\$250 copay per admission
<b>Physician and other services including surgeon fees</b>	No charge
<b><u>Home Health Care</u></b>	\$15 copay per visit
Coverage is limited to 100 visits per benefit period.	
<b><u>Therapy Services</u></b>	
<b>Rehabilitation and Habilitation services including physical, occupational and speech therapies.</b>	
Office	\$15 copay per visit
Outpatient Hospital	\$30 copay per visit
<b>Pulmonary rehabilitation</b>	
Office	\$15 copay per visit
Outpatient Hospital	\$30 copay per visit
<b>Cardiac rehabilitation</b>	
Office	\$15 copay per visit
Outpatient Hospital	\$30 copay per visit
<b>Dialysis/Hemodialysis office and outpatient hospital</b>	\$30 copay per visit
<b>Chemo/Radiation Therapy office and outpatient hospital</b>	\$30 copay per visit

Covered Medical Benefits	Cost if you use an In-Network Provider
<b>Skilled Nursing Care (facility)</b> <i>Coverage is limited to 100 days per benefit period.</i>	No charge
<b>Inpatient Hospice</b>	No charge
<b><u>Additional Services, Equipment and Devices</u></b>	
<b>Durable Medical Equipment</b>	20% coinsurance
<b>Prosthetic Devices</b>	No charge
<b>Hearing Aids</b> <i>Coverage is limited to 1 item per ear every 36 months.</i>	20% coinsurance

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
<b>Pharmacy Deductible</b>	Not applicable	Not covered
<b>Pharmacy Out-of-Pocket Limit</b>	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.

**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.

<b>Tier 1 - Typically Generic</b>	\$15 copay per prescription (retail) and \$30 copay per prescription (home delivery)	Not covered (retail and home delivery)
<b>Tier 2 - Typically Preferred Brand</b>	\$30 copay per prescription (retail) and \$75 copay per prescription (home delivery)	Not covered (retail and home delivery)
<b>Tier 3 - Typically Non-Preferred Brand</b>	\$50 copay per prescription (retail) and \$125 copay per prescription (home delivery)	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
	delivery)	
<b>Tier 4 - Typically Specialty (brand and generic)</b>	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
<p><i>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.</i></p>		
<b>Children's Vision exam (up to age 19)</b> Limited to 1 exam per benefit period.	No charge	Not covered
<b>Adult Vision exam (age 19 and older)</b> 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.*

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

# Your summary of benefits



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
<p>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 <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> and select the HMO Chiropractic/Acupuncture Network (American Specialty Health Plans).</p>		
<p><b>Your First Visit</b> 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.</p>		
<p><b>Services Must be Approved</b> All services must be approved as Medically Necessary except for:</p>		
<ul style="list-style-type: none"><li>• 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</li><li>• Emergency Services.</li></ul>		
<p>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.</p>		
<p><b>Services Not Approved</b> 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.</p>		
<p><b><u>Visits in an Office &amp; Outpatient</u></b></p>		
<p><b>Chiropractic Care</b> <i>Coverage is limited to 30 visits per benefit period. Benefit limit is for office and outpatient combined.</i></p>	\$10 copay per visit	Not covered
<p><b><u>Diagnostic Services</u></b></p>		
<p><b>Lab</b> <b>Chiropractic labs</b> <i>Covered when prescribed by a chiropractor that is an In-Network Provider and approved as Medically Necessary.</i></p>	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
<b>Chiropractic X-Ray</b> <i>Covered when prescribed by a chiropractor that is an In-Network Provider and approved as Medically Necessary.</i>	Covered at the same cost share percentage as Diagnostic X-ray.	Not covered
<b>Durable Medical Equipment</b>  <b>Chiropractic appliances</b> <i>Covered when prescribed by a chiropractor that is an In-Network Provider and approved as Medically Necessary.</i>	\$50 maximum of Chiropractic Appliances per Benefit Period.	Not covered

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*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, 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 envíemos 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

ՈՒԾԱՐԴՈՒԹՅՈՒՆ. 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 ինդրում 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، تو اندنمي اگر بخوانيد؟ را نامه اين توانيد می آيا : مهم کند کمک شما به آن خواندن در بخواهيم شخصی از توانيمی زبان به و کتبی صورت به را نامه اين بتوانيد است ممکن همچنین با فوراً لطفاً، رايگان کمک دریافت برای. کنید دریافت خودتان تماس (711) 1-888-254-2721. (TTY/TDD: 711) شماره بگيريد.

### 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、支援することができます。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៖ តើអ្នកអាចអាជីវកម្មសំបុត្រឯទេ៖លានទេ៖  
តើអ្នកតែងទេ យើងអាចបានអ្នកជួយអាជីវកម្ម៖  
អ្នកតែងអាចទទួលបានសំបុត្រឯទេ៖សរសេរជាតិការណ៍  
របស់អ្នកដែងទៅ ស្របតាមជំនួយដោយ  
តាតគិតថ្លែង ស្របទូរសព្ទមកតាមច្បាប់រយៈលេខ  
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।  
ਮੁਫ਼ਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਤੁਰੱਤ 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

ສໍາຄັນ: ຄຸນສາມາດຮອ່ານຈດໝາຍນີ້ໄດ້ແກ້ໄຂໂນມ  
ໜາກຄຸນຮອ່ານຈດໝາຍນີ້ໄມ້ໄດ້ ເຮົາສາມາດຮອ່ານຂອ້າ

ໄຄຣສັກຄນ່າວຍຄຸນຮອ່ານໄດ້ ຄຸນສາມາດຮອ່ານຈດໝາຍນີ້  
ທີ່ເຂີຍນີ້ໃນກາໝາຂອງຄຸນໄດ້ເຊັ່ນກັນ  
ໜາກຕ້ອງການຄວາມໝ່າຍແລລ້ວແບບໄນ້ມີຄໍາໃຈໆຈ່າຍ  
ໂປຣໂທຮາເຮາໄດ້ທັນທີ 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>