

Your summary of benefits



Anthem® Blue Cross

Your Plan: Green Dot Public Schools (CA): Custom Premier HMO

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	\$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, prescription drugs at a retail pharmacy, 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. (Excluding Infertility treatment)

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 <i>virtual and office</i>	\$10 copay per visit
Specialist Care <i>virtual and office</i>	\$20 copay per visit
<u>Other Practitioner Visits</u>	
Maternity services	
Prenatal and Postnatal care	\$10 copay per visit
Delivery	\$200 copay per pregnancy
Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i>	\$10 copay per visit
Manipulation Therapy <i>Coverage is limited to 60 days per benefit period.</i>	\$10 copay per visit

Covered Medical Benefits	Cost if you use an In-Network Provider
Acupuncture	\$10 copay per visit
<u>Other Services in an Office</u>	
Allergy Testing	\$10 copay per visit
Prescription Drugs <i>Dispensed in the office</i> <i>Maximum of \$150 member cost share per drug.</i>	20% coinsurance
Surgery	\$10 copay per surgery
Preventive care / screenings / immunizations	No charge
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge
<u>Diagnostic Services</u>	
Lab	
Office	No charge
Freestanding Lab	No charge
Outpatient Hospital	No charge
X-Ray	
Office	No charge
Freestanding Radiology Center	No charge
Outpatient Hospital	No charge
Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i>	
Office	No charge
Freestanding Radiology Center	No charge
Outpatient Hospital	No charge
<u>Emergency and Urgent Care</u>	
Urgent Care <i>includes doctor services. Additional charges may apply depending on the care provided.</i>	In-Network and Out-of-Network Providers: \$10 copay per visit
Emergency Room Facility Services <i>Your copay will be waived if admitted.</i>	In-Network and Out-of-Network Providers: \$100 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: \$100 copay per trip

Covered Medical Benefits	Cost if you use an In-Network Provider
Outpatient Mental Health and Substance Use Disorder Services at a Facility Facility Fees Doctor Services	No charge No charge
<u>Outpatient Surgery</u> Facility Fees Hospital Ambulatory Surgical Center Physician and other services <i>including surgeon fees</i> Hospital	\$100 copay per visit \$100 copay per visit No charge
<u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u> <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> Facility Fees Physician and other services <i>including surgeon fees</i>	\$200 copay per admission No charge
Home Health Care <i>Coverage is limited to 100 visits per benefit period.</i>	\$10 copay per visit
Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies.</i> <i>Coverage for physical, occupational and speech therapies is limited to 60 visits combined per benefit period.</i> Office Outpatient Hospital	\$10 copay per visit \$10 copay per visit
Pulmonary rehabilitation <i>office and outpatient hospital</i>	\$10 copay per visit
Cardiac rehabilitation <i>office and outpatient hospital</i>	\$10 copay per visit
Dialysis/Hemodialysis <i>office and outpatient hospital</i>	\$10 copay per visit
Chemo/Radiation Therapy <i>office and outpatient hospital</i>	\$10 copay per visit
Skilled Nursing Care (facility) <i>Coverage is limited to 100 days per benefit period.</i>	No charge
Inpatient Hospice	No charge
Durable Medical Equipment	20% coinsurance

Covered Medical Benefits	Cost if you use an In-Network Provider
Prosthetic Devices	No charge
Infertility Treatment Coverage is limited to \$2,000 maximum per benefit period. Not Covered: Reversals of elective sterilizations	50% coinsurance

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with In-Network medical out-of-pocket limit	Combined with Out-of-Network medical out-of-pocket limit
Prescription Drug Coverage Network: Rx Choice Tiered 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 Preferred Network and 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.			
Tier 1 - Typically Generic	\$15 copay per prescription (retail and home delivery)	\$25 copay per prescription (retail) and Not covered (home delivery)	50% coinsurance up to \$250 per prescription (retail) and Not covered (home delivery)
Tier 2 - Typically Preferred Brand	\$35 copay per prescription (retail) and \$70 copay per prescription (home delivery)	\$45 copay per prescription (retail) and Not covered (home delivery)	50% coinsurance up to \$250 per prescription (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	\$70 copay per prescription (retail) and \$140 copay per prescription (home delivery)	\$80 copay per prescription (retail) and Not covered (home delivery)	50% coinsurance up to \$250 per prescription (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	20% coinsurance up to \$150 per prescription (retail) and 20% coinsurance up to \$300 per prescription (home delivery)	20% coinsurance up to \$150 per prescription (retail) and Not covered (home delivery)	50% coinsurance up to \$250 per prescription (retail) and Not covered (home delivery)

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
	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.

Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Questions: (855) 333-5730 or visit us at 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
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.		
<u>Visits in an Office & Outpatient</u> Chiropractic Care <i>Coverage is limited to 30 visits per benefit period. Benefit limit is for office and outpatient combined.</i>	\$10 copay per visit	Not covered
<u>Diagnostic Services</u> Lab Chiropractic labs <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 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 <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
<u>Durable Medical Equipment</u> Chiropractic appliances <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

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.

Intentionally Left Blank

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 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 (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>