

Your summary of benefits



Anthem® Blue Cross

Your Plan: Association for Los Angeles Deputy Sheriffs, Inc.: Custom 2026 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	No charge
Specialist care	No charge

Covered Medical Benefits	Cost if you use an In-Network Provider
Overall Deductible	\$0 person
Overall Out-of-Pocket Limit	\$1,000 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 deductibles, copayments and coinsurance apply to the out-of-pocket limit. (Excluding prescription drug for Out-of-Network Providers)

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) <i>virtual and office</i>	No charge
Specialist Provider <i>virtual and office</i>	No charge
Other Practitioner Visits	
Maternity Doctor services (prenatal/postpartum care and delivery)	No charge
Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i>	No charge
Manipulation Therapy <i>via medical group</i> <i>You may have up to a 60 day period of care after an illness or injury.</i>	No charge
Manipulation Therapy <i>via ASH plan provider</i> <i>An initial examination by an ASHP chiropractor is required. Up to 35 visits per benefit period if authorized as medically necessary by ASHP.</i>	\$10 copay per visit

Covered Medical Benefits	Cost if you use an In-Network Provider
Acupuncture	No charge
<u>Other Services in an Office</u>	
Allergy Testing	No charge
Prescription Drugs <i>Dispensed in the office</i>	No charge
Surgery	No charge
Preventive care / screenings / immunizations	No charge
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge
<u>Diagnostic Services Lab</u>	
Office	No charge
Freestanding Lab	No charge
Outpatient Hospital	No charge
<u>Diagnostic Services X-Ray</u>	
Office	No charge
Freestanding Radiology Center	No charge
Outpatient Hospital	No charge
<u>Diagnostic Services Advanced Diagnostic Imaging</u> <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: No charge
Emergency Room Facility Services <i>Your copay will be waived if admitted.</i>	In-Network and Out-of-Network Providers: \$25 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: No charge

Covered Medical Benefits	Cost if you use an In-Network Provider
<u>Outpatient Surgery</u> Facility Fees Hospital Ambulatory Surgical Center Physician and other services <i>including surgeon fees</i> Hospital	 No charge No charge No charge
<u>Hospital (Including Maternity)</u> Facility Fees Physician and other services <i>including surgeon fees</i>	 No charge No charge
<u>Home Health Care</u>	No charge
<u>Therapy Services</u> Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies.</i> <i>You may have up to a 60 day period of care after an illness or injury.</i> Office Outpatient Hospital	 No charge No charge
Pulmonary rehabilitation <i>office and outpatient hospital</i>	No charge
Cardiac rehabilitation <i>office and outpatient hospital</i>	No charge
Dialysis/Hemodialysis <i>office and outpatient hospital</i>	No charge
Chemo/Radiation Therapy <i>office and outpatient hospital</i>	No charge
Skilled Nursing Care (facility) <i>Coverage is limited to 100 days per benefit period.</i>	No charge
Inpatient Hospice	No charge
<u>Additional Services, Equipment and Devices</u> Durable Medical Equipment	No charge
Prosthetic Devices	No charge
Wigs <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	No charge
Hearing Aids <i>Coverage is limited to 1 item per ear every 3 years.</i>	No charge

Covered Medical Benefits		Cost if you use an In-Network Provider	
Refractive Eye Surgeries Including astigmatic keratotomy, lamellar keratoplasty and laser procedures for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia), hyperopia (farsightedness) or astigmatism. Limited to a lifetime benefit of \$1,500/eye.		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 applicable	Not applicable
Pharmacy Out-of-Pocket Limit		Combined with In-Network medical out-of-pocket limit	Not applicable
Prescription Drug Coverage Network: <i>Base Network</i> Drug List: <i>CA National DMHC</i> <i>If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.</i>			
Day Supply Limits: Retail Pharmacy <i>30 day supply (cost shares noted below)</i> Home Delivery Pharmacy <i>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.</i> Specialty Pharmacy <i>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.</i>			
Tier 1 - Typically Generic		\$10 copay per prescription (retail specialty, and \$5 copay per prescription (home delivery)	50% coinsurance up to \$250 per prescription (retail) and Not covered (specialty and home delivery)
Tier 2 - Typically Preferred Brand		\$20 copay per prescription (retail and specialty) and \$5 copay per prescription (home delivery)	50% coinsurance up to \$250 per prescription (retail) and Not covered (specialty and home delivery)
Tier 3 - Typically Non-Preferred Brand/Specialty Drugs		\$20 copay per prescription (retail and specialty) and \$5 copay per prescription (home delivery)	50% coinsurance up to \$250 per prescription (retail) and Not covered (specialty 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.
- Mental health and substance abuse benefits covered by The Holman Group.
- 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

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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 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>