Your summary of benefits

Anthem®

Anthem® Blue Cross

IBEW Local 18 Health & Welfare Trust: HMO

Your Plan: Anthem Custom Premier HMO 0/100% (Rx $5/$10)

Your Network: California Care HMO

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 and nervous disorders and substance abuse. Benefits are subject to all terms, conditions, limitations, and exclusions of the EOC.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$0 person	Not covered
Out-of-Pocket Limit *When you meet your out of pocket limit, you will no longer have to pay cost shares during the remainder of your benefit period. See notes for additional information regarding your out of pocket maximum*	Individual $500; Two-Party $1,000; Family $1,500	Not covered
The family out-of-pocket maximum is embedded, meaning the cost shares of one family member will be applied to the per single out-of-pocket maximum; in addition, amounts for all covered family members apply to the family out-of-pocket maximum. No one member will pay more than the per single out-of-pocket maximum. Your copays, coinsurance and deductible count toward your out of pocket amount(s).		
Preventive Care / Screening / Immunization *In-network preventative care is not subject to deductible if you plan has a deductible*	No Copay	Not covered
Preventive Care for Chronic Conditions *per IRS guidelines*	No Copay	Not covered
Virtual Care (Telemedicine / Telehealth Visits)		
Virtual Visits - Online visits with Doctors who also provide services in person		
Primary Care (PCP)	No Copay	Not covered
Mental Health and Substance Use Disorder care	Carved out to Optum Behavioral Health	Not covered
Specialist	No Copay	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Virtual Visits from Online Provider LiveHealth Online *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*		
Primary Care (PCP)	No Copay	Not covered
Mental Health and Substance Use Disorder	Carved out to Optum Behavioral Health	Not Covered
Specialist Care	No Copay	Not covered
Visits in an Office		
Primary Care (PCP)	No Copay	Not covered
Specialist Care	No Copay	Not covered
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	No Copay	Not covered
Retail Health Clinic	No Copay	Not covered
Chiropractic Services *An initial examination by an ASHP chiropractor and/or acupuncturist of disorders is required. Up to 30 visits combined during a calendar year if authorized as medically necessary by ASHP.*	$10 copay per visit	Not covered
Acupuncture	$10 copay per visit	Not covered
Chiropractic Appliances	$50 per calendar year	Not covered
Other Services in an Office		
Allergy Testing	No Copay	Not covered
Chemo/Radiation Therapy	No Copay	Not covered
Dialysis/Hemodialysis	No Copay	Not covered
Prescription Drugs *Dispensed in the office through infusion/injection*	No Copay	Not covered
Surgery	No Copay	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Diagnostic Services **Lab**		
Office	No Copay	Not covered
Freestanding Lab	No Copay	Not covered
Outpatient Hospital	No Copay	Not covered
X-Ray		
Office	No Copay	Not covered
Freestanding Radiology Center	No Copay	Not covered
Outpatient Hospital	No Copay	Not covered
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office *Cost may vary by site of service*	No Copay	Not covered
Freestanding Radiology Center *Cost may vary by site of service*	No Copay	Not covered
Outpatient Hospital *Cost may vary by site of service*	No Copay	Not covered
Emergency and Urgent Care		
Urgent Care *– in an office setting* *Cost may vary by site of service*	No Copay	Covered as In-Network
Emergency Room Facility Services *This is for the hospital/ facility charge only. The ER physician charge may be separate*	No Copay	Covered as In-Network
Emergency Room Doctor and Other Services	No Copay	Covered as In-Network
Ambulance (Air & Ground)	No Copay	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder		
Doctor Office Visit	Carved out to Optum Behavioral Health	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Facility Visit		
Facility Fees	Carved out to Optum Behavioral Health	Not covered
Doctor Services	Carved out to Optum Behavioral Health	Not covered
Outpatient Surgery		
Facility Fees		
Hospital	No Copay	Not covered
Freestanding Surgical Center	No Copay	Not covered
Doctor and Other Services	No Copay	Not covered
Hospital (Including Maternity) *Mental / Behavioral health and substance abuse is carved out to Optum Behavioral Health*		
Facility Fees *(for example, room & board)*	No Copay	Not covered
Doctor and other services	No Copay	Not covered
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 100 visits per benefit period. Applies to In-Network.*	No Copay	Not covered
Rehabilitation services		
Office *Coverage for In-Network Provider is limited to 60 day limit per benefit period for Physical, Occupational and Speech Therapy combined. Costs may vary by site of service. Chiropractor visits count towards your physical and occupational therapy limit.*	No Copay	Not covered
Outpatient Hospital *Coverage for In-Network Provider is limited to 60 day limit per benefit period for Physical, Occupational and Speech Therapy combined. Costs may vary by site of service.*	No Copay	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Habilitation Services *(For example, physical/speech/occupational therapy* Office *Coverage for In-Network provider is limited to 60 day limit per benefit period for Physical, Occupational and Speech Therapy combined. Cost may vary by site of service. Chiropractic visits count towards your physical and occupational therapy limit.* Outpatient Hospital *Coverage for In-Network Provider is limited to 60 day limit per benefit period for Physical, Occupational and Speech Therapy combined. Cost may vary by site of service.*	 No Copay No Copay	 Not covered Not covered
Cardiac rehabilitation Office *Coverage for In-Network Provider is limited to 60 day limit per benefit period for Physical, Occupational and Speech Therapy combined.* Outpatient Hospital *Coverage for In-Network Provider is limited to 60 day limit per benefit period for Physical, Occupational and Speech Therapy combined.*	 No Copay No Copay	 Not covered Not covered
Skilled Nursing Care (in a facility) *Coverage is limited to 100 days per benefit period. Applies to In-Network*	No Copay	Not covered
Hospice	No Copay	Not covered
Durable Medical Equipment	No Copay	Not covered
Prosthetic Devices	No Copay	Not covered
Refractive Eye Surgeries (LASIK benefit) *Including astigmatic keratotomy, lamellar kertoplasty and laser procedure 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. Costs vary by site of service.*	Plan pays $1,500 per eye, lifetime	Not covered

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	$0	$0
Home Delivery Pharmacy *Maintenance medication are available through CarelonRx 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.*		

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Preventive Pharmacy **Preventive Immunization**	No Copay	50% coinsurance (retail only)
Female oral contraceptive *Generic and Single Source brand*	No Copay	50% coinsurance (retail only)
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy). Per 90 day supply (home delivery). Member pays the retail pharmacy copay plus 50% for out of network. Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).*	$5 copay per prescription(retail) and $10 copay per prescription (home delivery)	Member pays the retail participating pharmacies copay plus 50% coinsurance (retail only)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy). Per 90 day supply (home delivery). Member pays the retail pharmacy copay plus 50% for out of network. Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).*	$10 copay per prescription(retail) and $20 copay per prescription (home delivery)	Member pays the retail participating pharmacies copay plus 50% coinsurance (retail only)

Notes:

- Behavioral Health and Substance abuse is covered through Optum Behavioral Health.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- Your plan requires selection of a Primary Care Physician. Your plan requires a referral from your Primary Care Physician for select covered services.
- In Network and Non Network pharmacy deductibles are combined. Satisfying one helps satisfy the other. Pharmacy deductibles are included in the annual out-of-pocket maximums.
- Infertility services are not included in the out of pocket amount.
- Certain drugs require pre-authorization approval to obtain coverage.
- Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.
- Coordination of Benefits: The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverage do not exceed 100% of the covered expense.
- Freestanding Lab and Radiology Center is defined as services received in a non-hospital based facility.
- In addition to the benefits described in this summary, coverage may include additional benefits, depending upon the member's home state. The benefits provided in this summary are subject to federal and California laws. There are some states that require more generous benefits be provided to their residents, even if the master policy was not issued in their state. If the member's state has such requirements, we will adjust the benefits to meet the requirements.
- Preventive Care Services includes physical exam, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunization, health education, intervention services, HIV testing) and additional preventive care for women provided for in the guidance supported by Health Resources and Service Administration.
- Respite Care limited to 5 consecutive days per admission.
- Skilled Nursing Facility day limit does not apply to mental health and substance abuse.

• Supply limits for certain drugs may be different, go to Anthem website or call customer service.
• Additional visits maybe authorized if medically necessary. Pre-service review must be obtained prior to receiving the additional services.
• This Summary of Benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this Summary of Benefits. This Summary of Benefits, as updated, is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care (as applicable).
• For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to https://le.anthem.com/pdf?x=CA_LG_HMO.
• When using non-network pharmacy, members are responsible for 50% of the prescription drug maximum allowed amount & costs in excess of the prescription drug maximum allowed amount. Members will pay upfront and submit a claim form

Your summary of benefits

Anthem®

Anthem® Blue Cross

Your Plan: Infertility Rider

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Infertility *In-network and non-network is not subject to deductible, if your plan has a deductible.*	50% coinsurance	Not covered
Out-of-Pocket Limit	Infertility services do **not** apply toward Out-of-Pocket Limit.	
Infertility Benefit Maximum	Anthem payment of $5,000 per lifetime per Member.	
Additional Covered Services includes artificial insemination, in-vitro fertilization, GIFT (gamete intrafallopian transfer), ZIFT (Zygote intra-fallopian transfer), supplies, appliances, and Drugs administered in a Physician's office. These services are subject to Coinsurance stated above and the $5,000 lifetime per Member maximum. Covered services also exist for diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis, and services to treat the underlying medical conditions that cause Infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency). These services are provided on the same basis, at the same cost shares, as any other medical condition and **not** subject to the above lifetime maximum. **Not Covered:** Reversals of elective sterilizations.		

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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 alternate 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? De lo contrario, podemos hacer que alguien lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721. (TTY/TDD: 711)

Arabic
مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاستعانة بشخص ما ليساعدك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم1-888-254-2721 (TTY/TDD:711).

Armenian
ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող ենք նաև այս նամակը Ձեզ գրավոր տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-888-254-2721 հեռախոսահամարով: (TTY/TDD: 711)

Chinese
重要事項：您能看懂這封信函嗎？如果您看不懂，我們能夠找人協助您。您有可能可以獲得以您的語言而寫的本信函。如需免費協助，請立即撥打1-888-254-2721。(TTY/TDD: 711)

Farsi
مهم: آیا می‌توانید این نامه را بخوانید؟ اگر نمی‌توانید، می‌توانیم شخصی را به شما معرفی کنیم تا در خواندن این نامه شما را کمک کند. همچنین می‌توانید این نامه را به صورت مکتوب به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، همین حالا با شماره 1-888-254-2721 تماس بگیرید.(TTY/TDD:711)

Hindi
महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम आपको इसे पढ़ने में मदद करने के लिए किसी को उपलब्ध करा सकते हैं। आप यह पत्र अपनी भाषा में लिखवाने में भी सक्षम हो सकते हैं। निःशुल्क मदद के लिए, कृपया 1-888-254-2721 पर तुरंत कॉल करें। (TTY/TDD: 711)

Hmong
TSEEM CEEB: Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwm tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

Japanese

重要：この書簡を読めますか？もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたものを入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。
1-888-254-2721 (TTY/TDD: 711)

Khmer
សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ យើងអាចឲ្យនរណាម្នាក់អានវាជូនអ្នក។ អ្នកក៏អាចទទួលលិខិតនេះជាភាសារបស់អ្នកផងដែរ។ ដើម្បីទទួលជំនួយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខ 1-888-254-2721។ (TTY/TDD: 711)

Korean
중요: 이 서신을 읽으실 수 있으십니까? 읽으실 수 없을 경우 도움을 드릴 사람이 있습니다. 귀하가 사용하는 언어로 쓰여진 서신을 받으실 수도 있습니다. 무료 도움을 받으시려면 즉시 1-888-254-2721로 전화하십시오. (TTY/TDD: 711)

Punjabi
ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸ ਇਹ ਪੱਤਰ ਪੜਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹ, ਤਾਂ ਅਸ ਇਸਨੂੰ ਪੜਹ ਿ ਵੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਿ ਕਸੇਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸ ਸ਼ਾਇਦ ਪੱਤਰਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਿ ਵੱਚ ਿ ਲਖਆ ਹੋਇਆ ਵਬੀ ਪਰ ਾਪ ਾਪ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਮਦਦ ਲਈ, ਿ ਕਰਪਾ ਕਰਕੇ ਫੋਰਨ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Russian
ВАЖНО. 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: Nababasa ba ninyo ang liham na ito? Kung hindi, may taong maaaring tumulong sa inyo sa pagbasa nito. Maaari ninyo ring makuha ang liham na ito nang nakasulat sa ginagamit ninyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai
หมายเหตส าคัญ: ทา่ นสามารถอา่ ไม่ หากท่านไม่สามารถอา่ นจดหมายฉบับนี้ นจดหมายฉบับนี้หรอ

เราสามารถจัดหาเจา้ หนา้ าอา่ ่านฟังได ทา่ นยังอาจใหเ้จา้ ่วยแปล นจดหมายในภาษาของทา่ ตวั ย ม นให้ท หนา้ ที่ นอก

หากตอ้ งการความชว่ ยเหลอ โดยไม่ม คา่ ใชจ้ ่าย ต่อท่ มายเลข 1-888-254-2721 (TTY/TDD: 711)
โปรดโทรตด

Vietnamese
QUAN TRỌNG: Quý vị có thể đọc thư này hay không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc thư này. Quý vị cũng có thể nhận thư này bằng ngôn ngữ của quý vị. Để được giúp đỡ miễn phí, vui lòng gọi ngay số 1-888-254-2721. (TTY/TDD: 711)

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with 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 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.