

Choosing and using your plan

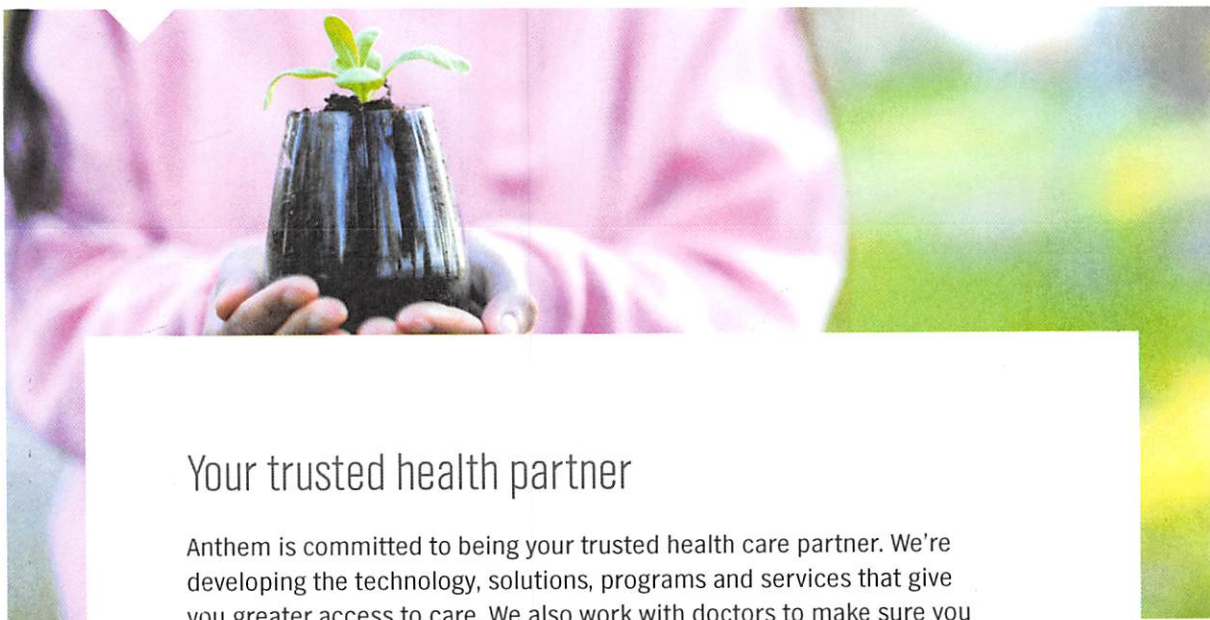
Your guide to open enrollment and
making the most of your benefits



Anthem Blue Cross Select HMO
Riverside Sheriff's Association
Effective January 1, 2020



It's time to choose your plan



Your trusted health partner

Anthem is committed to being your trusted health care partner. We're developing the technology, solutions, programs and services that give you greater access to care. We also work with doctors to make sure you get affordable, quality health care.

Save this guide

You'll find tips on how to make the most of your benefits and save on health care costs throughout the year.





It's time to choose your plan

Let's get started

This is the perfect time to think about your health — where you are right now and where you want to be tomorrow. It's your opportunity to check out the benefits, programs and resources that can support your health and well-being all year long.

This guide will help you understand our plans. It's also full of tips, tools and resources that can help you reach your health and wellness goals when you become a member. So keep it handy to make the most of your benefits throughout the year.



Table of contents

Choosing your plan

Using your plan

How to use your plan	4
The legal stuff we're required to tell you	18



Using your plan



How to use your plan

Once you've chosen a plan, explore how to make the most of your benefits. Here you'll learn simple ways to make using your plan easy. Plus, you'll discover tools and resources that can help you reach your health and wellness goals. With Anthem, supporting your healthiest self is all part of the plan!



How to use your plan

Use your ID card right from your phone

Introducing the **Sydney Health** mobile app. With **Sydney Health** you can find everything you need to know about your benefits – all in one place. You'll have a custom experience that's based on your plan, your specific health care needs and lots more. And you can quickly access your digital ID card to show it to your doctor. You can even use **Sydney Health** to track your health goals, find care, compare costs, and manage your claims.

Have a question? **Sydney Health** acts like a personal health guide, answering your questions and connecting you to the right resources at the right time. And you can use the chatbot to get answers quickly. **Sydney Health** makes it easier to get things done, so you can spend more time focusing on your health. Get started by downloading the **Sydney Health** mobile app.

Register for online tools and resources

Accessing your health plan on your mobile phone or computer makes life so much easier. Register on the **Sydney Health** mobile app and [anthem.com/ca](https://www.anthem.com/ca) to get personalized information about your health plan and more. You can:

- Quickly access your digital ID card.
- Find a doctor and estimate your costs before you go.
- View your claims, see what's covered and what you may owe for care.
- Get support managing your health conditions and tracking your goals.
- Update your email and communication preferences.



How to use your plan

Find a doctor in your plan

The right doctor can make all the difference — and choosing one in your plan can save you money, too. So you'll be happy to know your plan includes lots of top-notch doctors. If you decide to get care from doctors outside the plan, it'll cost you more and your care might not be covered at all.

It's easy to find a doctor in your plan. Simply use the **Find a Doctor** tool on the **Sydney Health** mobile app or at anthem.com/ca to search for doctors, hospitals, labs and other health care professionals.

Schedule a checkup

Preventive care, like regular checkups and screenings, can help you avoid health problems down the road. Your plan covers these services at little or no extra cost when you see a doctor in your plan:

- Yearly physicals
- Well-child visits
- Flu shot
- Routine shots
- Screenings and tests

Check your plan details on the **Sydney Health** mobile app or anthem.com/ca to confirm what preventive care is covered.

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 proposed benefit summary is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care

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 services provided under the "ReadyAccess" program, OB/GYN services received within the member's medical group/IPA, and services for all mental and nervous disorders and substance abuse. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Annual copay maximum: Individual \$1,000; Two-Party \$2,000; Family \$3,000

The following copay does not apply to the annual copay maximum: for infertility services. After an annual copay maximum is met for medical and prescription drugs during a calendar year, the individual member or family will no longer be required to pay a copay or coinsurance for medical and prescription drug covered expenses for the remainder of that year. The member remains responsible for non-covered expenses infertility services.

Covered Services	Per Member Copay
Inpatient Medical Services	
➤ Semi-private room or private room if medically necessary; meals and special diets; services and supplies	No copay
➤ Special care units	No copay
➤ Operating room and special treatment rooms	No copay
➤ Nursing care	No copay
➤ Drugs, medications & oxygen administered in the hospital	No copay
➤ Blood & blood products	No copay
Outpatient Medical Services <i>(hospital care other than emergency room services)</i>	No copay
Ambulatory Surgical Center	
➤ Outpatient surgery & supplies	No copay
Skilled Nursing Facility <i>(limited to 100 days/calendar year; limit does not apply to mental health and substance abuse)</i>	
➤ All necessary services & supplies <i>(excluding take-home drugs)</i>	No copay
Hospice Care <i>(Inpatient or outpatient services; family bereavement services)</i>	No copay
Home Health Care	
➤ Home visits when ordered by primary care physician <i>(limited to 100 visits/calendar year; one visit by a home health aide equals four hours or less)</i>	\$10/visit
Physician Medical Services	
➤ Office & home visits	\$10/visit
➤ Preferred Online Visit <i>(includes Mental/Behavioral Health and Substance Abuse)</i>	\$10/visit
➤ Retail Health Clinic	\$10/visit
➤ Hospital visits	No copay
➤ Skilled nursing facility visits	No copay
➤ Specialists & consultants	\$10/visit
Short-Term Physical, Occupational, or Speech Therapy, or Chiropractic Care when Ordered by the Primary Care Physician <i>(limited to a 60-day period of care after an illness or injury; additional visits available when approved by the medical group)</i>	\$10/visit
Acupuncture	\$10/visit

Covered Services	Per Member Copay
Surgical Services	
➤ Surgeon & surgical assistant	No copay
➤ Anesthesiologist or anesthetist	No copay
General Medical Services	
➤ Diagnostic X-ray & laboratory procedures (<i>including mammograms, pap smears, & prostate cancer screening</i>)	No copay
➤ Radiation therapy, chemotherapy & hemodialysis treatment	No copay
➤ Prosthetic devices	No copay
➤ Durable medical equipment including hearing aids (<i>hearing aids benefit is available for one hearing aid per ear every three years; breast pump and supplies are covered under preventive care at no charge</i>)	No copay
Preventive Care Services	
Preventive Care Services including*, physical exams, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunizations, health education, intervention services, HIV testing), and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration.	No copay
*This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.	
Health Education and Wellness Programs	
➤ Specified immunizations	No copay
➤ Allergy testing & treatment (<i>including serums</i>)	\$10/visit
➤ Selected health education programs	No copay
Emergency Care	
In Area (<i>within 20 miles of medical group</i>) and Out of Area	
➤ Physician & medical services	No copay
➤ Outpatient hospital emergency room services	\$50 /visit (<i>waived if admitted</i>)
➤ Inpatient hospital services	No copay
Ambulance Services	
➤ Ground or air ambulance transportation when medically necessary, including medical services & supplies	No copay
Pregnancy and Maternity Care	
Office Visits	
➤ Prenatal & postnatal care	\$10/visit
➤ Complications of pregnancy or abortions	\$10/visit
Normal Delivery or Cesarean Section, including:	
➤ Inpatient hospital & ancillary services	No copay
➤ Routine nursery care	No copay
➤ Physician services (<i>inpatient only</i>)	No copay
Complication of Pregnancy or Abortion, including:	
➤ Inpatient hospital & ancillary services	No copay
➤ Outpatient hospital services	No copay
➤ Physician services (<i>inpatient only</i>)	No copay
Abortions (<i>including prescription drug for abortion (mifepristone)</i>)	No copay
Genetic Testing of Fetus	No copay
Family Planning Services	
➤ Infertility studies & tests	50% of covered expense ¹
➤ Female Sterilization (<i>including tubal ligation and counseling/consultation</i>)	No copay
➤ Male Sterilization	\$50
➤ Counseling & consultation	No copay
Organ and Tissue Transplant	
➤ Inpatient Care	No copay
➤ Physician office visits (<i>including primary care, specialty care & consultants</i>)	\$10/visit

Covered Services	Per Member Copay
Mental or Nervous Disorders and Substance Abuse	
➤ Inpatient facility care (subject to utilization review; waived for emergency admissions)	No copay
➤ Inpatient physician visits	No copay
➤ Outpatient facility care	No copay
➤ Physician office visits (<i>Behavioral Health Treatment for Autism or Pervasive Development disorders require pre-service review</i>)	\$10/visit
Smoking Cessation Program	No copay

¹ Not applicable to the annual copay maximum

This Summary of Benefits is a brief review of benefits. Once enrolled, members will receive the Combined Evidence of Coverage and Disclosure Form, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.

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

anthem.com/ca Anthem Blue Cross GH2014 Effective 01-2020 Printed 09-2019



Modified Rx 19 Three Tier Prescription Drug Benefits

Rx Benefits

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 proposed benefit summary is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care.

PLEASE NOTE: *This is only a summary of your benefits. Please refer to your Combined Evidence of Coverage and Disclosure Form ("EOC")/Certificate of Insurance ("Certificate") which explains your plan's Exclusions and Limitations as well as the full range of your covered services in detail.*

At Anthem Blue Cross, we know that prescription drugs are the fastest-rising item of your total health care benefits cost. Reasons for the spiraling costs of prescription drugs are varied: a general increase of prescription medication use, an aging population, research and development of new medications and the expense of direct to consumer advertising. With prescription drug costs increasing at twice the rate of medical care, we developed ways to contain costs so your copays remain affordable, while maintaining your access to safe, effective prescription drugs. Our Prescription Drug Program provides you with choice, flexibility, affordability and access to an extensive network of retail pharmacies.

Getting a Prescription Filled at a Participating Pharmacy

To get a prescription filled, you need only take your prescription to a participating pharmacy and present your member ID card. The amount you pay for a covered prescription – your copay – will be determined by whether the drug is a brand-name or generic medication and whether it is a formulary or non-formulary medication.

A generic drug contains the same effective ingredients, meets the same standards of purity as its brand-name counterpart and typically costs less. In many situations, you have a choice of filling your prescription with a generic medication or a brand-name medication.

The formulary is a list of approximately 600 recommended brand and generic medications. These medications have undergone extensive review for therapeutic value for a particular medical condition, safety and cost. Copies of our formulary are furnished to your providers and are available online at anthem.com/ca/ under the Pharmacy section. You or your provider may also contact our Pharmacy Customer Service at (800) 700-2541.

The following chart illustrates the relation between drug type and your copay amount at a participating pharmacy:

Drug Type	Copay Amount
Generic	\$5.00
Brand name formulary	\$10.00
Brand name non-formulary	\$40.00

Finding a Participating Pharmacy

Because our huge pharmacy network includes major drugstore chains plus a wide variety of independent pharmacies, it is easy for you to find a participating pharmacy. You can also find a participating pharmacy by going to our website at anthem.com/ca/.

An Extensive Network

Besides saving you money, our extensive network of pharmacies offers you easy accessibility.

- In California there are over 5,100 retail pharmacies. This accounts for nearly 95% of retail pharmacies in the state, including all major chains.
- Nationwide there are more than 61,000 chain and independent pharmacies.

Using a Participating Pharmacy

You can substantially control the cost of your prescription drugs by using our extensive network of participating pharmacies. Participating pharmacies have agreed to charge a discounted price or "negotiated rate" and pass along this savings to you.

Using a Non-Participating Pharmacy

If you choose to fill your prescription at a non-participating pharmacy, your costs will increase. You will likely need to pay for the entire amount of the prescription and then submit a prescription drug claim form for reimbursement. The pharmacist must sign and complete the appropriate section of the claim form to ensure proper processing of the claim for reimbursement.

Members that submit claims from non-participating pharmacies are reimbursed based on a **limited fee schedule**. The fee schedule may be considerably less than the cost of the medication. You are responsible for paying any difference.

The following chart illustrates potential increased out-of-pocket expenses for going to a non-participating pharmacy:

	Out-of-pocket costs using a participating pharmacy	Out-of-pocket costs using a non-participating pharmacy
Pharmacy's normal charge for brand-name formulary drug	\$50.00	\$50.00
You are responsible for:	\$10.00 copay	50% of the limited fee schedule plus any amounts exceeding the fee schedule up to \$250
Total out-of-pocket expenses	\$10.00	Expense varies based on the cost of the medication

You may obtain a prescription drug claim form by calling Pharmacy Customer Service at the toll-free number printed on your member ID card or by going to our website at anthem.com/ca/.

Home Delivery Prescription Drug Program

If you take a prescription drug on a regular basis, you may want to take advantage of our home delivery program. Ordering your medications by mail is convenient, saves time and depending on your plan design, may even save you money. Besides enjoying the convenience of home delivery, you will also receive a greater supply of medications. To fill a prescription through the mail, simply complete the Home Delivery Prescription form. You may obtain the form by calling Customer Service, at the toll-free number listed on your ID card or by going to our website at anthem.com/ca/. Once you complete the form, simply mail it with your copy and prescription in the envelope attached to the Home Delivery brochure. Please note that not all medications are available through the Home Delivery Program. Specialty pharmacy drugs are not available through the home delivery program, see Specialty Pharmacy Program below.

Out-Of-State Prescription Benefits

Our national network of participating pharmacies is available to members when outside California. To find a participating pharmacy, a member can check our Web site or call the toll-free number printed on the ID card. When using a non-participating pharmacy outside of California, the member will follow the same procedures for using a non-participating pharmacy in California as outlined above.

Additional Features That are Part of your Plan

Prior authorization as the term implies, is similar to prior authorization for medical services. Prior authorization applies to a select pool of medications that are often a second line of therapy. To require prior authorization, a drug must meet specific criteria. This criteria is based, among other things, on FDA-approved drug indications, targeted populations and the current availability of effective drug therapies. Prior authorization drugs are not covered unless you receive an approval from Anthem Blue Cross.

We distribute instructions on how to obtain prior authorization to physicians and pharmacies so that you may obtain prior authorization for required medications. You may call Pharmacy Customer Service, at the toll-free number printed on your member ID card, to receive a prior authorization form and/or list of medications requiring prior authorization.

Supply limits are the proper FDA recommendations for prescription medication dosage coupled with our determination of specific quantity supply limits to prescription medications. Although our standard pharmacy plans offer a 30-day supply for medications at a retail pharmacy, the supply limit can vary based on the medication, dosage and usage prescribed by your physician. For example, the supply limit for antibiotics used to treat an infection (e.g., 14 pills to be taken twice a day for one week) is different than blood pressure medication taken on a routine basis (e.g., 120 pills to be taken twice a day for 60 days). By adhering to specified supply limits, members are assured of receiving the appropriate amount of medication.

Specialty Pharmacy Program

Specialty medications are usually dispensed as an injectable drug, but may be available in other forms, such as a pill or inhalant. They are used to treat complex conditions. Prescriptions for a specialty pharmacy drug are covered only when ordered through the specialty pharmacy program unless you are given an exception from the specialty drug program (see your EOC for details). The specialty pharmacy program will deliver your medication to you by mail or common carrier (you cannot pick up your medication). You may have to pay the full cost of a specialty pharmacy drug if it is not obtained from the specialty pharmacy program. Specialty drugs are limited to a 30-day supply for each fill.

Programs for Member's Special Health Needs

We recognize that some of our members have unique health care needs requiring special attention. That's why we developed programs exclusively for them. Our additional medical management programs work in synergy with our pharmacy drug program to help members better manage their health care on an ongoing basis.

Diabetic members can receive **free glucometers** so that they can effectively and conveniently monitor their glucose levels.

Seniors can better monitor their chronic diseases and multiple medications through our **seniors-at-risk program**. This program reduces the possibility of toxic drug interactions, and curtails distribution of medications that may adversely affect the senior's chronic condition.

Asthmatic members and their families can take advantage of our program to better control the frequency and severity of the disease.

Members who take multiple prescription medications can take advantage of our pharmacy utilization management programs that encourage the safe, effective distribution of prescription medications. We have a program that protects the welfare of members with multiple prescription medications by carefully monitoring their prescription therapy to help reduce the danger of toxic drug interaction. For additional information regarding your prescription drug benefits, please call Pharmacy Customer Service at the toll-free number printed on your member ID card. Please refer to your Combined Evidence of Coverage and Disclosure Form which explains your plan's Exclusions and Limitations as well as the full range of your covered services in detail.

Covered Services (outpatient prescriptions only)	Per Member Cost Share for Each Prescription or Refill
Prescription Drug Coverage	
This plan uses a National Drug List. Drugs not on the list are not covered.	
Retail Pharmacy	
➤ Preventive immunizations administered by a retail pharmacy	No copay
➤ Female oral contraceptives generic and single source brand	No copay
➤ Generic drugs	\$5
➤ Brand name formulary drugs	\$10
➤ Brand name non-formulary drugs ¹	\$40
➤ Compound drugs	\$10
➤ Self-administered injectable drugs, except insulin	20% of prescription drug covered expenses (maximum \$100 copay per fill)
Home Delivery	
➤ Female oral contraceptives generic and single source brand	No copay
➤ Generic drugs	\$10
➤ Brand name formulary drugs	\$20
➤ Brand name non-formulary drugs ¹	\$80
➤ Self-administered injectable drugs, except insulin	20% of prescription drug covered expenses (maximum \$100 copay)
Specialty Pharmacy Drugs (obtained through specialty pharmacy program)	
➤ Generic drugs	\$5
➤ Brand name drugs	\$10
➤ Brand name non-formulary drugs ¹	\$40
➤ Self-administered injectable drugs, except insulin	20% of prescription drug covered expenses (maximum \$ 100 copay per fill)
Non-participating Pharmacies (compound drugs & specialty pharmacy drugs not covered)	
	Member pays: 50% of the remaining prescription drug covered expense & costs in excess of the maximum amount allowed up to \$250 per prescription
Supply Limits²	
➤ Retail Pharmacy (participating and non-participating)	30-day supply; 60-day supply for federally classified Schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies); 90-day supply for eligible prescriptions obtained through a retail pharmacy, but will require a triple copay.
➤ Home Delivery	90-day supply
➤ Specialty Pharmacy	30-day supply

¹ When the member's physician has specified "dispense as written" (DAW) for non-formulary drugs, the copay for brand name formulary drugs will apply. When the member's physician has not specified DAW for non-formulary drugs, the higher copay will apply.

² Supply limits for certain drugs may be different. Please refer to the Evidence of Coverage and Disclosure form (EOC) for complete information.

The Prescription Drug Benefit covers the following:

- All eligible immunizations administered by a participating retail pharmacy.
- Outpatient prescription drugs and medications which the law restricts to sale by prescription.
- Formulas prescribed by a physician for the treatment of phenylketonuria. These formulas are subject to the copay for brand name drugs.
- Folic acid supplementation prescribed by a physician for women planning to become pregnant (folic acid supplement or a multivitamin prescribed by a physician).
- Aspirin prescribed by a physician for the reduction of heart attack or stroke prescribed by a physician.
- Smoking cessation products and over-the-counter nicotine replacement products (limited to nicotine patches and gum) as prescribed by a physician.
- Prescription drugs prescribed by a physician to eliminate or reduce dependency on, or addiction to, tobacco and tobacco products.
- Insulin.
- Syringes when dispensed for use with insulin and other self-injectable drugs or medications
- All FDA-approved contraceptives for women, including oral contraceptives; contraceptive diaphragms and over-the-counter contraceptives prescribed by a doctor.
- Injectable drugs which are self-administered by the subcutaneous route (under the skin).
- Drugs that have Food and Drug Administration (FDA) labeling for self-administration.
- All compound prescription drugs that contain at least one covered prescription ingredient.
- Diabetic supplies (i.e., test strips and lancets).
- Prescription drugs for treatment of impotence and/or sexual dysfunction are limited to organic (non-psychological) causes.
- Inhaler spacers and peak flow meters for the treatment of pediatric asthma. These items are subject to the copay for brand name drugs.
- Certain over-the-counter drugs approved by the Pharmacy and Therapeutics Committee to be included in the prescription drug formulary.

Prescription drug cost shares are included in the medical out-of-pocket maximum. See medical plan summary of benefits for details.

Prescription Drug Exclusions & Limitations

Hypodermic syringes &/or needles, except when dispensed for use with insulin & other self-injectable drugs or medications

Drugs & medications used to induce spontaneous & non-spontaneous abortions

Drugs & medications dispensed or administered in an outpatient setting, including outpatient hospital facilities and physicians' offices

Professional charges in connection with administering, injecting or dispensing drugs

Drugs & medications that may be obtained without a physician's written prescription, except insulin or niacin for cholesterol lowering and certain over-the-counter drugs approved by the Pharmacy and Therapeutics Committee to be included in the prescription drug formulary.

Drugs & medications dispensed by or while confined in a hospital, skilled nursing facility, rest home, sanatorium, convalescent hospital or similar facility

Durable medical equipment, devices, appliances & supplies, even if prescribed by a physician, except contraceptive diaphragms, as specified as covered in the EOC

Services or supplies for which the member is not charged

Oxygen

Cosmetics & health or beauty aids.

Drugs labeled "Caution, Limited by Federal Law to Investigational Use," or Non-FDA approved investigational drugs. Any drugs or medications prescribed for experimental indications

Any expense for a drug or medication incurred in excess of (a) the drug limited fee schedule for drugs dispensed by non-participating pharmacies; or (b) the prescription drug negotiated rate for drugs dispensed by participating pharmacies or through the mail service program

Drugs which have not been approved for general use by the State of California Department of Health Services or the Food and Drug Administration. This does not apply to drugs that are medically necessary for a covered condition.

Prescription drugs that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material, thus treating a disease or abnormal medical condition.

Over-the-counter smoking cessation drugs. This does not apply to medically necessary drugs that the member can only get with a prescription under state and federal law.

Drugs used primarily for cosmetic purposes (e.g., Retin-A for wrinkles). However, this will not apply to the use of this type of drug for medically necessary treatment of a medical condition other than one that is cosmetic.

Drugs used primarily to treat infertility (including, but not limited to, Clomid, Pergonal and Metrodin), unless medically necessary for another covered condition.

Anorexiants and drugs used for weight loss, except when used to treat morbid obesity (e.g., diet pills & appetite suppressants)

Drugs obtained outside the U.S., unless they are furnished in connection with urgent care or an emergency.

Allergy desensitization products or allergy serum

Infusion drugs, except drugs that are self-administered subcutaneously

Herbal supplements, nutritional and dietary supplements, except for formulas for the treatment of phenylketonuria.

Prescription drugs with a non-prescription (over-the-counter) chemical and dose equivalent except insulin. This does not apply if an over-the-counter equivalent was tried and was ineffective.

Compound medications obtained from other than a participating pharmacy. Member will have to pay the full cost of the compound drugs if member obtains drug at a non-participating pharmacy. Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but, which are obtained from a retail pharmacy are not covered by this plan. Member will have to pay the full cost of the specialty pharmacy drugs obtained from a retail pharmacy that member should have obtained from the specialty pharmacy program.

Third Party Liability

Anthem Blue Cross is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

Any service, drug, drug regimen, treatment, or supply furnished, ordered or prescribed by a provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies. This exclusion does not apply to an emergency medical condition.

Please refer to the Certificate or EOC for details and complete list of exclusions and limitations. Exclusion does not apply to the medically necessary treatment as specifically stated as covered in the EOC/Certificate.

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The benefits described in this Rider are provided through an agreement between Anthem Blue Cross and American Specialty Health Plans of California (ASH Plans). The services listed below are covered only if provided by an ASH Plans Chiropractor. These benefits are provided in addition to the benefits described in the Anthem Blue Cross HMO Evidence of Coverage (EOC) document. However, when expenses are incurred for treatment received from an ASH Plans Chiropractor, no other benefits other than the benefits described in this Rider will be paid.

Covered Services	Member's Copayment
Office Visit	\$5/visit
Maximum Benefits	
Office Visits to a Chiropractor	20 visits per calendar year
Chiropractic appliances	\$50 per calendar year

Covered Services

The Chiropractic Rider provides coverage for the following:

Chiropractor Services. Member has up to 20 visits per calendar year for chiropractor care services that are determined by ASH Plans to be medically/clinically necessary. All visits to an ASH Plans chiropractor will be applied towards the maximum number of visits in a calendar year. The ASH Plans chiropractor is responsible for submitting a treatment plan to ASH Plans for prior approval.

Covered services include:

- An initial new patient exam by an ASH Plans chiropractor to determine the appropriateness of chiropractic services.
- Follow-up office visits as set forth in a treatment plan approved by ASH Plans and provided by an ASH Plans chiropractor.
- An established patient exam performed by an ASH Plans chiropractor to assess the need to continue, extend or change a treatment plan approved by ASH Plans.
- Adjunctive physiotherapy modalities and procedures as set forth in a treatment plan approved by ASH Plans and provided by ASH Plans chiropractor.
- Radiological x-rays and laboratory tests when prescribed by an ASH Plans chiropractor and approved by ASH Plans. Covered services include radiological consultations when determined by ASH Plans to be medically/clinically necessary and provided by a licensed chiropractic radiologist, medical radiologist, radiology group or hospital which has contracted with ASH Plans to provide those services.
- Chiropractic Appliances. Up to \$50 per calendar year when prescribed by an ASH Plans chiropractor and approved by ASH Plans. Covered chiropractic appliances are limited to:
 - elbow supports, back supports (thoracic), lumbar braces and supports, rib supports, or wrist supports;
 - cervical collars or cervical pillows;
 - ankle braces, knee braces, or wrist braces;
 - heel lifts;
 - hot or cold packs;
 - lumbar cushions;
 - rib belts or orthotics; and
 - home traction units for treatment of the cervical or lumbar regions.

Chiropractic Rider Exclusions & Limitations

Care Not Approved: Any services provided by an ASH Plans chiropractor that are not approved by ASH Plans, except as specified as covered in the Evidence of Coverage (EOC). An ASH Plans chiropractor is responsible for submitting a treatment plan to ASH Plans for prior approval.

Care Not Covered: In addition to any service or supply specifically excluded in the EOC, no benefits will be provided for chiropractic services or supplies in connection with:

- Diagnostic scanning, such as magnetic resonance imaging (MRI) or computerized axial tomography (CAT) scans.
- Thermography.
- Hypnotherapy.
- Behavior training
- Sleep therapy
- Weight programs.
- Any non-medical program or service.
- Pre-employment exams, any chiropractic services required by an employer that are not medically/clinically necessary, or vocational rehabilitation.
- Services and/or treatments which are not documented as medically/clinically necessary.
- Massage therapy.
- Any service or supply for the exam and/or treatment by an ASH Plans chiropractor for conditions other than those related to neuromusculoskeletal disorders.
- Transportation costs including local ambulance charges.
- Education programs, non-medical self-care or self-help, or any self-help physical exercise training or any related diagnostic testing.
- Hospitalization, surgical procedures, anesthesia, manipulation under anesthesia, proctology, colonic irrigation, injections and injection services, or other related services.
- All auxiliary aids and services, including, but not limited to, interpreters, transcription services; written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephone compatible with hearing aids;
- Adjunctive therapy not associated with spinal, muscle or joint manipulation.

- Laboratory and diagnostic x-ray studies, except as specified as covered in the EOC.

Non-ASH Plans Chiropractors: Services and supplies provided by a chiropractor who does not have an agreement with ASH Plans to provide covered services under this plan.

Work Related: Care for health problems that are work-related if such health problems are covered by workers' compensation, an employer's liability law or similar law. We will provide care for a work-related health problem, but we have the right to be paid back for that care as described in the EOC.

Government Treatment: Any services actually given to the member by a local, state or federal government agency, except when this plan's benefits, must be provided by law. We will not cover payment for these services if the member is not required to pay for them or they are given to the member for free.

Drugs: Prescription drugs or medicines, including a non-legend or proprietary medicine or medication not requiring a prescription.

Supplements: Vitamins, minerals, dietary and nutritional supplements or other similar products, and any herbal supplements.

Air Conditioners: Air purifiers, air conditioners, humidifiers, supplies or any other similar devices or appliances. All appliances or durable medical equipment, except as specified as covered in the EOC.

Personal Items: Any supplies for comfort, hygiene or beauty purposes, including therapeutic mattresses.

Out-Of-Area and Emergency Care: Out-of-area care is not covered under this Chiropractic Care benefit, except for emergency services. The member should follow the procedures specified by their Anthem Blue Cross HMO plan to obtain emergency or out-of-area care.

Third Party Liability

Anthem Blue Cross is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

Anthem Blue Cross is the trade name of Blue Cross of California. Independent Licensee of the Blue Cross Association. ® ANTHEM is a registered trademark. ® The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Get help in your language

Notice of Language Assistance



Curious to know what all this says? We would be too. Here's the English version: No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-888-254-2721. For more help call the CA Dept. of Insurance at 1-800-927-4357. (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

Servicios lingüísticos sin costo. Puede tener un intérprete. Puede solicitar que le lean los documentos y algunos puede recibirlos en su idioma. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-888-254-2721. Para obtener ayuda adicional, llame al Departamento de Seguros de California al 1-800-927-4357.

Arabic

يتم تقديم خدمات اللغة دون مقابل. يمكنك الاستعانة بمترجم. ويمكنك المطالبة بأن تُقرأ لك بعض المستندات وأن يُرسل بعضها بلغتك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة التعريف الخاصة بك أو على الرقم 1-888-254-2721 للحصول على مزيد من المساعدة، يُرجى الاتصال بإدارة كاليفورنيا للتأمين على الرقم 1-800-927-4357.

Armenian

Թարգմանչական անվճար ծառայություններ: Մենք կարող ենք Ձեզ թարգմանչի ծառայություններ առաջարկել Կարող ենք տրամադրել ինչ-որ մեկին, ով փաստաթղթերը կկարդա Ձեզ համար և կուղարկի դրանք Ձեր լեզվով: Օգնություն ստանալու համար զանգահարեք մեզ Ձեզ ID քարտի վրա նշված հեռախոսահամարով կամ 1-888-254-2721 համարով: Լրացուցիչ օգնության համար զանգահարեք Կալիֆոռնիայի ապահովագրության նախարարություն հետևյալ հեռախոսահամարով՝ 1-800-927-4357:

Chinese

免費語言服務。您能獲得免費的譯員。您能聽到以您的語言讀出的文件內容，也能獲得以您的語言而寫的部分文件。如需協助，請撥打您的 ID 卡上的號碼或者 1-888-254-2721 聯絡我們。如需更多協助，請撥打 1-800-927-4357 聯絡 CA Dept. of Insurance。

Farsi

خدمات رایگان زبانی. می‌توانید یک مترجم شفاهی بگیرید. می‌توانید بخواهید اسناد را برای شما بخوانند و برخی اسناد نیز به زبان خودتان برایتان ارسال شود. برای دریافت کمک، از طریق شماره فهرست شده در کارت شناسایی‌تان و یا از طریق 1-888-254-2721 با ما تماس بگیرید. برای دریافت کمکهای بیشتر با اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تماس بگیرید.

Hindi

बिना लागत की भाषा सेवाएँ। आप दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेज़ पढ़वा सकते हैं और कुछ दस्तावेज़ आपको आपकी भाषा में भेजे जा सकते हैं। मदद के लिए, हमें अपने ID कार्ड पर सूचीबद्ध नंबर पर या 1-888-254-2721 पर कॉल करें। अधिक मदद के लिए 1-800-927-4357 पर CA बीमा विभाग को कॉल करें।

Hmong

Tsis Xam Tus Nqi Cov Kev Pab Cuam Ntsig Txog Hom Lus. Koj muaj peev xwm tau txais ib tus neeg txhais lus. Koj muaj peev xwm tau txais cov ntaub ntawv nyceem ua koj hom lus rau koj mloog thiab yuav xa ib co ntaub ntawv sau ua koj hom lus tuaj rau koj. Txog rau kev pab, hu rau pcb tus nab npawb xov tooj tceev tscg cia nyob rau ntawm koj daim ID los sis 1-888-254-2721. Txog rau kev pab ntxiv, hu xov tooj rau Pab Kas Phais Lub Chaw Ua Hauj Lwm CA tus xov tooj 1-800-927-4357.

Japanese

無料言語サービス。通訳サービスを受けられます。希望する言語で文書を読み上げたり、文書を送るサービスも可能です。支援を受けるには、IDカードに記載された番号、または 1-888-254-2721 にお電話ください。支援の詳細は、カリフォルニア州保険局 (1-800-927-4357) にお電話ください。

Khmer

សេវាភាសាខ្មែរគឺឥតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែម្នាក់។ អ្នកអាចឲ្យគេអានឯកសារផ្សេងៗជូនអ្នក និងផ្ញើឯកសារជូនអ្នកជាភាសារបស់អ្នក។ ដើម្បីទទួលបានជំនួយ សូមហៅ ទូរស័ព្ទមកយើងតាមលេខដែលបានរាយនៅលើប័ណ្ណ ID របស់អ្នក ឬក៏លេខ 1-888-254-2721។ ដើម្បីទទួលបានជំនួយបន្ថែម សូមហៅទូរស័ព្ទទៅ CA Dept. of Insurance តាមលេខ 1-800-927-4357។

Korean

무료 언어 서비스. 번역사를 이용하실 수 있습니다. 귀하의 언어로 녹음되어 작성된 문서를 받아보실 수 있습니다. 도움을 받으시려면 ID 카드에 기재된 번호 또는 1-888-254-2721로 전화하십시오. 다른 도움이 필요하시면 1-800-927-4357로 보험 CA 부서에 문의 주십시오.

Punjabi

ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਦੇ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਆ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਕੋਈ ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਪੜ੍ਹ ਕੇ ਸੁਣਾ ਸਕਦਾ ਹੈ ਅਤੇ ਕੁਝ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਤੁਹਾਨੂੰ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਸਾਨੂੰ ਤੁਹਾਡੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਸੂਚੀਬੱਧ ਨੰਬਰ ਜਾਂ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। ਜ਼ਿਆਦਾ ਮਦਦ ਲਈ, ਸੀਏ ਡਿਪਾਰਟਮੈਂਟ ਔਫ ਇਨਸ਼ੂਰੈਂਸ ਨੂੰ 1-800-927-4357 ਤੇ ਕਾਲ ਕਰੋ।

Russian

Бесплатные языковые услуги. Вы можете получить услуги устного переводчика. Вам могут прочитать документы или направить некоторые из них на вашем языке. Для получения помощи звоните нам по телефону, указанному на вашей идентификационной карте, или по номеру 1-888-254-2721. Для получения дополнительной помощи звоните в Департамент страхования штата Калифорния по номеру 1-800-927-4357.

Tagalog

Mga Libreng Serbisyo para sa Wika. Maaari kayong kumuha ng interpreter. Maaari ninyong ipabasa ang mga dokumento at ipadala ang ilan sa mga ito sa inyo sa wikang ginagamit ninyo. Para sa tulong, tawagan kami sa numerong nakalista sa inyong ID card o sa 1-888-254-2721. Para sa higit pang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357.

Thai

ไม่มีค่าบริการเกี่ยวกับภาษาท่านสามารถขอใช้บริการล่ามได้ ท่านสามารถขอให้เจ้าหน้าที่อ่านเอกสารได้ท่านฟังและเอกสารบางอย่างจะส่งถึงท่านโดยใช้ภาษาของท่านหากต้องการความช่วยเหลือโปรดโทรหาเราตามหมายเลขที่ระบุอยู่บนบัตรประชาชนของท่านหรือที่หมายเลข 1-888-254-2721 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรติดต่อแผนก CA Dept. of Insurance ที่หมายเลข 1-800-927-4357

Vietnamese

Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có thông dịch viên. Quý vị có thể yêu cầu đọc tài liệu cho quý vị nghe và yêu cầu gửi một số tài liệu bằng ngôn ngữ của quý vị cho quý vị. Để được trợ giúp, hãy gọi cho số được ghi trên thẻ ID của quý vị hoặc số 1-888-254-2721. Để được giúp đỡ thêm, hãy gọi cho Sở Bảo Hiểm California (California Department of Insurance) theo số 1-800-927-4357.

TTY/TTD: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/TTD: 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>.



The legal stuff we're required to tell you

How we keep your information safe and secure

As a member, you have the right to expect us to protect your personal health information. We take this responsibility very seriously, following all state and federal laws, as well as our own policies.

You also have certain rights and responsibilities when receiving your health care. To learn more about how we protect your privacy, your rights and responsibilities when receiving health care, and your rights under the Women's Health and Cancer Rights Act, go to anthem.com/ca/privacy. For a printed copy, please contact your Benefits Administrator or Human Resources representative.

How we help manage your care

To see if your health benefits will cover a treatment, procedure, hospital stay or medicine, we use a process called utilization management (UM). Our UM team is made up of doctors and pharmacists who want to be sure you get the best treatments for certain health conditions. They review the information your doctor sends us before, during or after your treatment. We also use case managers. They're licensed health care professionals who work with you and your doctor to help you manage your health conditions. They also help you better understand your health benefits.

To learn more about how we help manage your care, go to anthem.com/ca/memberrights. To request a printed copy, please contact your Benefits Administrator or Human Resources representative.

Special enrollment rights

Open enrollment usually happens once a year. That's the time you can choose a plan, enroll in it or make changes to it. If you choose not to enroll, there are special cases when you're allowed to enroll during other times of the year.

- **If you had another health plan that was canceled.** If you, your dependents or your spouse are no longer eligible for benefits with another health plan (or if the employer stops contributing to that health plan), you may be able to enroll with us. You must enroll within 31 days after the other health plan ends (or after the employer stops paying for the plan). For example: You and your family are enrolled through your spouse's health plan at work. Your spouse's employer stops paying for health coverage. In this case, you and your spouse, as well as other dependents, may be able to enroll in one of our plans.
- **If you have a new dependent.** You gain new dependents from a life event like marriage, birth, adoption or if you have custody of a minor and an adoption is pending. You must enroll within 31 days after the event. For example: If you got married, your new spouse and any new children may be able to enroll in a plan.
- **If your eligibility for Medicaid or SCHIP changes.** You have a special period of 60 days to enroll after:
 - You (or your eligible dependents) lose Medicaid or the State Children's Health Insurance Program (SCHIP) benefits because you're no longer eligible.
 - You (or eligible dependents) become eligible to get help from Medicaid or SCHIP for paying part of the cost of a health plan with us.

Get the full details

Read your **Certificate of Coverage**, which spells out all the details about your plan. You can find on anthem.com/ca.