Your summary of benefits

Anthem BlueCross

Anthem Blue Cross

Your Plan: Value Deductible HMO $1,500 25/40/25% (Essential Formulary $5/$20/$40/$75/30% $250 Deductible)

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 *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$1,500 per member	$0
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 section for additional information regarding your out of pocket maximum.*	$3,000 single / $6,000 family	$0
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	Not covered
Doctor Home and Office Services		
Primary care visit to treat an injury or illness	$25 copay per visit	Not covered
Specialist care visit	$40 copay per visit	Not covered
Prenatal and Post-natal Care	$25 copay per visit	Not covered
Other practitioner visits: Retail health clinic	Not covered	Not covered

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
On-line Visit	Not covered	Not covered
Chiropractor services *Coverage for In-Network Provider is limited to 60 day limit per benefit period for Physical, Occupational and Speech Therapy combined. Chiropractor visits count towards your physical and occupational therapy limit.*	$25 copay per visit	Not covered
Acupuncture	$25 copay per visit	Not covered
Other services in an office:		
Allergy testing	$25 copay per visit	Not covered
Chemo/radiation therapy	$40 copay per visit	Not covered
Hemodialysis	$40 copay per visit	Not covered
Prescription drugs *For the drugs itself dispensed in the office thru infusion/injection*	30% coinsurance up to $150 per visit	Not covered
Diagnostic Services		
Lab:		
Office	No charge	Not covered
Freestanding Lab	No charge	Not covered
Outpatient Hospital *Deductible applies.*	25% coinsurance	Not covered
X-ray:		
Office	No charge	Not covered
Freestanding Radiology Center	No charge	Not covered
Outpatient Hospital *Deductible applies.*	25% coinsurance	Not covered
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office	$100 copay per test	Not covered

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Costs may vary by site of service.		
Freestanding Radiology Center *Costs may vary by site of service.*	$100 copay per test	Not covered
Outpatient Hospital *Deductible applies. Costs may vary by site of service.*	25% coinsurance	Not covered
Emergency and Urgent Care		
Emergency room facility services *This is for the hospital/facility charge only. The ER physician charge may be separate. Copay waived if admitted. Deductible applies.*	$150 copay and then 25% coinsurance	Covered as In-Network
Emergency room doctor and other services	No charge	Covered as In-Network
Ambulance (air and ground)	$100 copay per trip for ground and air	Covered as In-Network
Urgent Care (office setting) *Copay waived if admitted. Costs may vary by site of service.*	$25 copay per visit	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit	$25 copay per visit medical deductible does not apply	Not covered
Facility visit:		
Facility fees	No charge Medical deductible does not apply	Not covered
Outpatient Surgery		
Facility fees:		
Hospital *Deductible applies.*	25% coinsurance	Not covered
Freestanding Surgical Center *Deductible applies.*	25% coinsurance	Not covered
Doctor and other services	No charge	Not covered
Hospital Stay (all inpatient stays including maternity, mental /		

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
behavioral health, and substance abuse)		
Facility fees (for example, room & board) *Deductible applies.*	25% coinsurance	Not covered
Doctor and other services	No charge	Not covered
Recovery & Rehabilitation		
Home health care *Coverage for In-Network Provider is limited to 100 visit limit per benefit period.*	$25 copay per visit	Not covered
Rehabilitation 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. Costs may vary by site of service. Chiropractor visits count towards your physical and occupational therapy limit.*	$25 copay per visit	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. Deductible applies.*	25% coinsurance	Not covered
Habilitation services *Habilitation visits count towards your rehabilitation limit. Deductible applies.*	25% coinsurance	Not covered
Cardiac rehabilitation		
Office	$25 copay per visit	Not covered
Outpatient hospital *Deductible applies.*	25% coinsurance	Not covered
Skilled nursing care (in a facility) *Coverage for In-Network Provider is limited to 100 day limit per benefit period. Deductible applies.*	25% coinsurance	Not covered
Hospice	No charge *Medical deductible does*	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
	not apply.	
Durable Medical Equipment	50% coinsurance	Not covered
Prosthetic Devices	No charge	Not covered

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	$250 single / $750 family	$250 single / $750 family
Pharmacy Out of Pocket	Combined with medical out of pocket	Combined with medical out of pocket
Prescription Drug Coverage *This plan uses an Essential formulary List. Drugs not on the list are not covered.*		
Tier1 - Typically Generic *Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program) Prescription Drug deductible does not apply. This plan uses an Essential Formulary drug list. You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Member pays the retail pharmacy copay plus 50% for out of network.*	Tier1a - Typically Lower Cost Generic $5 copay per prescription (retail only) and $12.50 copay per prescription (home delivery only) Tier1b - Typically Generic $20 copay per prescription (retail only) and $50 copay per prescription (home delivery only).	Tier 1a 50% coinsurance up to $250 per prescription (retail only) Tier 1b 50% coinsurance up to $250 per prescription (retail only).
Tier2 - Typically Preferred / Brand *Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program) Member pays the retail pharmacy copay plus 50% for out of network.*	Tier 2 - Typically Preferred Brand & non-preferred generic drugs $40 copay per prescription (retail only) and $120 copay per prescription (home delivery only).	Tier 2 - 50% coinsurance up to $250 per prescription (retail only).
Tier3 - Typically Non-Preferred / Specialty Drugs *Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply*	Tier 3 - Typically Non-Preferred	Tier 3 - 50% coinsurance up to

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
(home delivery program) Member pays the retail pharmacy copay plus 50% for out of network.	Brand and generic drugs $75 copay per prescription (retail only) and $225 copay per prescription (home delivery only.	$250 per prescription (retail only).
Tier4 - Typically Specialty Drugs *Classified specialty drugs must be obtained through our Specialty Pharmacy Program and are subject to the terms of the program. Covers up to a 30 day supply (retail pharmacy and home delivery program) . Member pays the retail pharmacy copay plus 50% for out of network.*	Tier 4 - Typically Specialty (brand and generic) 30% coinsurance up to $250 per prescription (retail and home delivery).	Tier 4 - 50% coinsurance up to $250 per prescription (retail only).

Your summary of benefits

Notes:

- 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).
- 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.
- Your plan requires a selection of a Primary Care Physician. Your plan requires a referral from your Primary Care Physician for select covered services.
- The medical deductible applies to certain services such as: services in an inpatient/outpatient facility, emergency room. A separate pharmacy deductible applies to pharmacy benefits for applicable plans.
- 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.
- For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement is based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- 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.
- Additional visits maybe authorized if medically necessary. Pre-service review must be obtained prior to receiving the additional services.
- Skilled Nursing Facility day limit does not apply to mental health and substance abuse.
- Respite Care limited to 5 consecutive days per admission.
- Freestanding Lab and Radiology Center is defined as services received in a non-hospital based facility.
- Infertility services are not included in the out of pocket amount.
- 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
- When using non-network pharmacy; members are responsible for in-network pharmacy copay plus 50% of the remaining prescription drug maximum allowed amount & costs in excess of the prescription drug maximum allowed amount. Members will pay upfront and submit a claim form.
- Supply limits for certain drugs may be different, go to Anthem website or call customer service.
- Certain drugs require pre-authorization approval to obtain coverage.

- 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
- For additional information on this plan, please visit sbc.anthem.com to obtain a Summary of Benefit Coverage.