Your summary of benefits

Anthem BlueCross

Anthem Blue Cross of California

Your Plan: Anthem Silver HMO 1500/35%/7150

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 person / $3,000 family	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 section for additional information regarding your out of pocket maximum.*	$7,150 person / $14,300 family	Not Covered
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	$40 copay per visit	Not covered
Specialist care visit	$80 copay per visit	Not covered
Prenatal and Post-natal Care *In-Network preventative prenatal and postnatal services are covered at 100%*	$40 copay per visit	Not covered
Other practitioner visits:		
Retail health clinic	$35 copay per visit	Not covered
On-line Visit	Not covered	Not covered

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Chiropractor services *Coverage for In-Network Providers is limited to 20 visits per benefit period.*	$40 copay per visit	Not covered
Acupuncture	$40 copay per visit	Not covered
Other services in an office:		
Allergy testing	$40 copay per visit	Not covered
Chemo/radiation therapy	35% coinsurance	Not covered
Hemodialysis	35% coinsurance	Not covered
Prescription drugs *For the drugs itself dispensed in the office thru infusion/injection*	35% coinsurance deductible does not apply	Not covered
Diagnostic Services		
Lab:		
Office	$25 copay per visit	Not covered
Freestanding Lab	Not Applicable	Not Applicable
Outpatient Hospital	35% coinsurance after deductible is met	Not covered
X-ray:		
Office	$25 copay per visit	Not covered
Freestanding Radiology Center	Not Applicable	Not Applicable
Outpatient Hospital	35% coinsurance after deductible is met	Not covered
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office	$80 copay per visit	Not covered
Freestanding Radiology Center	Not Applicable	Not Applicable
Outpatient Hospital	35% coinsurance after deductible is met	Not covered
Emergency and Urgent Care		

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency room facility services *Copay waived if admitted.*	$250 copay and then 35% coinsurance after deductible is met	Same as In Network
Emergency room doctor and other services	35% coinsurance after deductible is met	Same as In Network
Ambulance (air and ground)	35% coinsurance after deductible is met	Same as In Network
Urgent Care (office setting)	$50 copay per visit	Not covered
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit	$40 copay per visit	Not covered
Facility visit:		
Facility fees	35% coinsurance after deductible is met	Not covered
Outpatient Surgery		
Facility fees:		
Hospital	35% coinsurance after deductible is met	Not covered
Freestanding Surgical Center	Not Applicable	Not Applicable
Doctor and other services	No charge	Not covered
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)		
Facility fees (for example, room & board) *Coverage for Inpatient rehabilitation and skilled nursing services combined In-Network Providers is limited to 100 days per benefit period.*	35% coinsurance after deductible is met	Not covered
Doctor and other services	No charge	Not covered

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Recovery & Rehabilitation		
Home health care *Coverage for In-Network Providers is limited to 100 visits per benefit period.*	$40 copay per visit	Not covered
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office	$40 copay per visit	Not covered
Outpatient hospital	35% coinsurance after deductible is met	Not covered
Habilitation services	35% coinsurance after deductible is met	Not covered
Cardiac rehabilitation		
Office	$40 copay per visit	Not covered
Outpatient hospital	35% coinsurance after deductible is met	Not covered
Skilled nursing care (in a facility) *Coverage for Inpatient rehabilitation and skilled nursing services combined In-Network Providers is limited to 100 days per benefit period.*	35% coinsurance after deductible is met	Not covered
Hospice	35% coinsurance after deductible is met	Not covered
Durable Medical Equipment	50% coinsurance after deductible is met	Not covered
Prosthetic Devices	35% coinsurance after deductible is met	Not covered

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Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	$250 person/$500 family	$0
Pharmacy Out of Pocket	Combined with medical out of pocket	Not covered
Prescription Drug Coverage *Anthem Select Drug List*		
Tier 1a - Typically Lower Cost Generic *You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Covers up to a 90 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.*	$5 copay per prescription (retail only) and $13 copay per prescription (home delivery only)	Not covered
Tier 1b - Typically Generic *Covers up to a 90 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.*	$20 copay per prescription (retail only) and $50 copay per prescription (home delivery only)	Not covered
Tier 2 - Typically Preferred Brand & Non-Preferred Generics *Covers up to a 90 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.*	$50 copay per prescription after deductible is met (retail only) and $150 copay per prescription after deductible is met (home delivery only)	Not covered
Tier 3 - Typically Non-Preferred Brand *Covers up to a 90 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.*	$90 copay per prescription after deductible is met (retail only) and $270 copay per prescription after deductible is met	Not covered

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
	(home delivery only)	
Tier 4 - Typically Specialty (brand and generic) *Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program). No coverage for non-formulary drugs. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.*	30% coinsurance up to $250 after deductible is met (retail and home delivery)	Not covered

Your summary of benefits

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. *Only children's vision services count towards your out of pocket limit.*		
Children's Vision Essential Health Benefits		
Child Vision Deductible	Not Applicable	Not Covered
Vision exam *Coverage for In-Network Providers is limited to 1 exam per benefit period.*	No charge	Not covered
Frames *Coverage for In-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Lenses *Coverage for In-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Elective contact lenses *Coverage for In-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Non-Elective Contact Lenses *Coverage for In-Network Providers is limited to 1 unit per benefit period.*	No charge	Not covered
Adult Vision		
Adult Vision Deductible	Not Applicable	Not Covered
Vision exam *Coverage for In-Network Providers is limited to 1 exam per benefit period.*	$20 copay per visit	Not covered
Frames	Not covered	Not covered
Lenses	Not covered	Not covered
Elective contact lenses	Not covered	Not covered
Non-Elective Contact Lenses	Not covered	Not covered

Your summary of benefits

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your dental coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. *Only children's dental services count towards your out of pocket limit.*		
Children's Dental Essential Health Benefits **Diagnostic and preventive** *Coverage for In-Network Providers is limited to 1 visit per 6 months.*	No charge	Not covered
Basic services	50% coinsurance after deductible is met	Not covered
Major services	50% coinsurance after deductible is met	Not covered
Medical Necessary Orthodontia services	50% coinsurance after deductible is met	Not covered
Cosmetic Orthodontia services	Not covered	Not covered
Deductible *Applies to all services except diagnostic & preventive*	Combined with medical deductible	Combined with medical deductible
Adult Dental		
Diagnostic and preventive	Not covered	Not covered
Basic services	Not covered	Not covered
Major services	Not covered	Not covered
Deductible	Not Applicable	Not Applicable
Annual maximum	Not Applicable	Not Applicable

Notes:

- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.
- Coverage for Non-emergency ambulance service for Non-Network Providers is limited to $50,000 maximum benefit per occurrence.
- For additional information on this plan, please visit sbc.anthem.com to obtain a "Summary of Benefit Coverage".
- For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to ca.sgplans.anthem.com/ca/le
- If your plan includes a hospital stay copay and you are readmitted within 72 hours of a prior admission for the same diagnosis, your hospital stay copay for your readmission is waived.
- Your copays, coinsurance and deductible count toward your out of pocket amount.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- If your plan includes out of network benefits and you use a non-participating provider, you are responsible for any difference between the covered expense and the actual non-participating providers charge.
- For plans with an office visit copay, the copay applies to the actual office visit and additional cost shares may apply for any other service performed in the office (i.e., X-ray, lab, surgery), after any applicable deductible.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.