

# Your summary of benefits



Anthem Blue Cross of California

Your Plan: Anthem Silver HMO 1750/40%/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
<b>Overall Deductible</b> <i>See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.</i>	\$1,750 person / \$3,500 family	Not Covered
<b>Out-of-Pocket Limit</b> <i>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.</i>	\$7,150 person / \$14,300 family	Not Covered
<b>Preventive care/screening/immunization</b> <i>In-network preventive care is not subject to deductible, if your plan has a deductible.</i>	No charge	Not covered
<b>Doctor Home and Office Services</b>		
<b>Primary care visit to treat an injury or illness</b>	\$45 copay per visit	Not covered
<b>Specialist care visit</b>	\$90 copay per visit	Not covered
<b>Prenatal and Post-natal Care</b> <i>In-Network preventative prenatal and postnatal services are covered at 100%</i>	\$45 copay per visit	Not covered
<b>Other practitioner visits:</b>		
Retail health clinic	\$35 copay per visit	Not covered
On-line Visit	\$35 copay per visit	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 <i>Coverage for In-Network Providers is limited to 20 visits per benefit period.</i>	\$45 copay per visit	Not covered
Acupuncture	\$45 copay per visit	Not covered
<b>Other services in an office:</b>		
Allergy testing	\$45 copay per visit	Not covered
Chemo/radiation therapy	40% coinsurance	Not covered
Hemodialysis	40% coinsurance	Not covered
Prescription drugs <i>For the drugs itself dispensed in the office thru infusion/injection</i>	40% coinsurance	Not covered
<b>Diagnostic Services</b>		
<b>Lab:</b>		
Office	\$25 copay per visit	Not covered
Freestanding Lab	Not Applicable	Not Applicable
Outpatient Hospital	40% coinsurance after deductible is met	Not covered
<b>X-ray:</b>		
Office	\$25 copay per visit	Not covered
Freestanding Radiology Center	Not Applicable	Not Applicable
Outpatient Hospital	40% coinsurance after deductible is met	Not covered
<b>Advanced diagnostic imaging (for example, MRI/PET/CAT scans):</b>		
Office	\$90 copay per visit	Not covered
Freestanding Radiology Center	Not Applicable	Not Applicable
Outpatient Hospital	40% coinsurance after deductible is met	Not covered
<b>Emergency and Urgent Care</b>		

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Emergency room facility services</b> <i>Copay waived if admitted.</i>	\$250 copay and then 40% coinsurance after deductible is met	Same as In Network
<b>Emergency room doctor and other services</b>	40% coinsurance after deductible is met	Same as In Network
<b>Ambulance (air and ground)</b>	40% coinsurance after deductible is met	Same as In Network
<b>Urgent Care (office setting)</b>	\$50 copay per visit	Not covered
<b>Outpatient Mental/Behavioral Health and Substance Abuse</b> <b>Doctor office visit</b> <b>Facility visit:</b> Facility fees	\$45 copay per visit  40% coinsurance after deductible is met	Not covered  Not covered
<b>Outpatient Surgery</b> <b>Facility fees:</b> Hospital  Freestanding Surgical Center <b>Doctor and other services</b>	40% coinsurance after deductible is met  Not Applicable No charge	Not covered  Not Applicable Not covered
<b>Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)</b> <b>Facility fees (for example, room &amp; board)</b> <i>Coverage for Inpatient rehabilitation and skilled nursing services combined In-Network Providers is limited to 100 days per benefit period.</i> <b>Doctor and other services</b>	40% coinsurance after deductible is met  No charge	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
<b>Recovery &amp; Rehabilitation</b> <b>Home health care</b> <i>Coverage for In-Network Providers is limited to 100 visits per benefit period.</i>	\$45 copay per visit	Not covered
<b>Rehabilitation services (for example, physical/speech/occupational therapy):</b> Office Outpatient hospital  Habilitation services	\$45 copay per visit  40% coinsurance after deductible is met  40% coinsurance after deductible is met	Not covered  Not covered  Not covered
<b>Cardiac rehabilitation</b> Office Outpatient hospital	\$45 copay per visit  40% coinsurance after deductible is met	Not covered  Not covered
<b>Skilled nursing care (in a facility)</b> <i>Coverage for Inpatient rehabilitation and skilled nursing services combined In-Network Providers is limited to 100 days per benefit period.</i>	40% coinsurance after deductible is met	Not covered
<b>Hospice</b>	40% coinsurance after deductible is met	Not covered
<b>Durable Medical Equipment</b>	50% coinsurance after deductible is met	Not covered
<b>Prosthetic Devices</b>	40% 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
<b>Pharmacy Deductible</b>	\$0	\$0
<b>Pharmacy Out of Pocket</b>	Combined with medical out of pocket	Not covered
<b>Prescription Drug Coverage</b> <i>Anthem Select Drug List</i>		
<b>Tier 1a - Typically Lower Cost Generic</b> <i>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.</i>	\$5 copay per prescription (retail only) and \$13 copay per prescription (home delivery only)	Not covered
<b>Tier 1b - Typically Generic</b> <i>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.</i>	\$20 copay per prescription (retail only) and \$50 copay per prescription (home delivery only)	Not covered
<b>Tier 2 - Typically Preferred Brand &amp; Non-Preferred Generics</b> <i>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.</i>	\$50 copay per prescription (retail only) and \$150 copay per prescription (home delivery only)	Not covered
<b>Tier 3 - Typically Non-Preferred Brand</b> <i>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.</i>	\$90 copay per prescription (retail only) and \$270 copay per prescription (home delivery only)	Not covered
<b>Tier 4 - Typically Specialty (brand and generic)</b> <i>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.</i>	30% coinsurance up to \$250 after deductible is met	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
	(retail and home delivery)	

# Your summary of benefits

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><i>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.</i></p> <p><i>Only children's vision services count towards your out of pocket limit.</i></p>		
<p><b>Children's Vision Essential Health Benefits</b></p> <p><b>Child Vision Deductible</b></p> <p><b>Vision exam</b> <i>Coverage for In-Network Providers is limited to 1 exam per benefit period.</i></p>	Not Applicable No charge	Not Covered Not covered
<p><b>Frames</b> <i>Coverage for In-Network Providers is limited to 1 unit per benefit period.</i></p>	No charge	Not covered
<p><b>Lenses</b> <i>Coverage for In-Network Providers is limited to 1 unit per benefit period.</i></p>	No charge	Not covered
<p><b>Elective contact lenses</b> <i>Coverage for In-Network Providers is limited to 1 unit per benefit period.</i></p>	No charge	Not covered
<p><b>Non-Elective Contact Lenses</b> <i>Coverage for In-Network Providers is limited to 1 unit per benefit period.</i></p>	No charge	Not covered
<p><b>Adult Vision</b></p> <p><b>Adult Vision Deductible</b></p> <p><b>Vision exam</b> <i>Coverage for In-Network Providers is limited to 1 exam per benefit period.</i></p>	Not Applicable \$20 copay per visit	Not Covered Not covered
<p><b>Frames</b></p>	Not covered	Not covered
<p><b>Lenses</b></p>	Not covered	Not covered
<p><b>Elective contact lenses</b></p>	Not covered	Not covered
<p><b>Non-Elective Contact Lenses</b></p>	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
<p><i>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.</i></p>		
<b>Children's Dental Essential Health Benefits</b> <b>Diagnostic and preventive</b> <i>Coverage for In-Network Providers is limited to 1 visit per 6 months.</i>	No charge	Not covered
<b>Basic services</b>	50% coinsurance after deductible is met	Not covered
<b>Major services</b>	50% coinsurance after deductible is met	Not covered
<b>Medical Necessary Orthodontia services</b>	50% coinsurance after deductible is met	Not covered
<b>Cosmetic Orthodontia services</b>	Not covered	Not covered
<b>Deductible</b> <i>Applies to all services except diagnostic &amp; preventive</i>	Combined with medical deductible	Not Applicable
<b>Adult Dental</b>		
<b>Diagnostic and preventive</b>	Not covered	Not covered
<b>Basic services</b>	Not covered	Not covered
<b>Major services</b>	Not covered	Not covered
<b>Deductible</b>	Not Applicable	Not Applicable
<b>Annual maximum</b>	Not Applicable	Not Applicable



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## 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](http://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](http://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.