

# Your summary of benefits



Anthem Blue Cross

Your Plan: Modified Classic HMO 10/30/250 Admit/125 OP

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>	\$0	\$0
<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>	\$2,000 single / \$4,000 family	\$0
<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>	\$10 copay per visit	Not covered
<b>Specialist care visit</b>	\$30 copay per visit	Not covered
<b>Prenatal and Post-natal Care</b>	\$10 copay per visit	Not covered
<b>Other practitioner visits:</b>		
Retail health clinic	\$10 copay per visit	Not covered
Preferred On-line Visit <i>Includes Mental/Behavioral Health and Substance Abuse.</i>	\$10 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
<p>Chiropractor services <i>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.</i></p> <p>Acupuncture</p>	<p>\$10 copay per visit</p> <p>\$10 copay per visit</p>	<p>Not covered</p> <p>Not covered</p>
<p><b>Other services in an office:</b></p> <p>Allergy testing</p> <p>Chemo/radiation therapy</p> <p>Hemodialysis</p> <p>Prescription drugs <i>For the drug itself dispensed in the office thru infusion/injection.</i></p>	<p>\$10 copay per visit</p> <p>\$30 copay per visit</p> <p>\$30 copay per visit</p> <p>30% coinsurance up to \$150 per visit</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><b>Diagnostic Services</b></p> <p><b>Lab:</b></p> <p>Office</p> <p>Freestanding Lab</p> <p>Outpatient Hospital</p>	<p>No charge</p> <p>No charge</p> <p>No charge</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><b>X-ray:</b></p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>No charge</p> <p>No charge</p> <p>No charge</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><b>Advanced diagnostic imaging (for example, MRI/PET/CAT scans):</b></p> <p>Office <i>Costs may vary by site of service.</i></p> <p>Freestanding Radiology Center <i>Costs may vary by site of service.</i></p> <p>Outpatient Hospital <i>Costs may vary by site of service.</i></p>	<p>\$100 copay per test</p> <p>\$100 copay per test</p> <p>\$100 copay per test</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>

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<p><b>Emergency and Urgent Care</b></p> <p><b>Emergency room facility services</b> <i>This is for the hospital/facility charge only. The ER physician charge may be separate. Copay waived if admitted.</i></p> <p><b>Emergency room doctor and other services</b></p>	<p>\$100 copay per visit</p> <p>No charge</p>	<p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p><b>Ambulance (air and ground)</b></p>	<p>\$100 copay per trip for ground and air</p>	<p>Covered as In-Network</p>
<p><b>Urgent Care (office setting)</b> <i>Copay waived if admitted. Costs may vary by site of service.</i></p>	<p>\$10 copay per visit</p>	<p>Covered as In-Network</p>
<p><b>Outpatient Mental/Behavioral Health and Substance Abuse</b></p> <p><b>Doctor office visit</b></p> <p><b>Facility visit:</b> Facility fees</p>	<p>\$10 copay per visit.</p> <p>No charge</p>	<p>Not covered</p> <p>Not covered</p>
<p><b>Outpatient Surgery</b></p> <p><b>Facility fees:</b> Hospital Freestanding Surgical Center</p> <p><b>Doctor and other services</b></p>	<p>\$125 copay per admission</p> <p>\$125 copay per admission</p> <p>No charge</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><b>Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)</b></p> <p><b>Facility fees (for example, room &amp; board)</b></p> <p><b>Doctor and other services</b></p>	<p>\$250 copay per admission</p> <p>No charge</p>	<p>Not covered</p> <p>Not covered</p>

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<p><b>Recovery &amp; Rehabilitation</b></p> <p><b>Home health care</b>  <i>Coverage for In-Network Provider is limited to 100 visit limit per benefit period.</i></p>	\$10 copay per visit	Not covered
<p><b>Rehabilitation services (for example, physical/speech/occupational therapy):</b></p> <p>Office  <i>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.</i></p> <p>Outpatient hospital  <i>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.</i></p>	\$10 copay per visit	Not covered
<p><b>Habilitation services (for example, physical/speech/occupational therapy):</b></p> <p>Office  <i>Coverage for In-Network Provider is limited to 60 visit limit per benefit period for Physical, Occupational and Speech Therapy combined. Chiropractic visits count towards your physical and occupational therapy limit.</i></p> <p>Outpatient hospital  <i>Coverage for In-Network Provider is limited to 60 visit limit per benefit period for Physical, Occupational and Speech Therapy combined.</i></p>	\$10 copay per visit	Not covered
<p><b>Cardiac rehabilitation</b></p> <p>Office  <i>Costs may vary by site of service.</i></p> <p>Outpatient hospital  <i>Costs may vary by site of service.</i></p>	\$30 copay per visit	Not covered
<p><b>Skilled nursing care (in a facility)</b>  <i>Coverage for In-Network Provider is limited to 100 day limit per benefit period.</i></p>	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
Hospice	No charge	Not covered
Durable Medical Equipment	20% coinsurance	Not covered
Prosthetic Devices	No charge	Not covered

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## 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.
- 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 types of physicians may not be represented in the PPO network in the state where the member receives services. If such physician is not available in the service area, the member's copay is the same as for PPO (with and without pre-notification, if applicable). Member is responsible for applicable copays, deductibles and charges which exceed covered expense.
- 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.
- Freestanding Lab and Radiology Center is defined as services received in a non-hospital based facility.
- Respite Care limited to 5 consecutive days per admission.
- 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.
- Coverage includes standard fertility preservation services as a basic healthcare service including but are not limited to, injections, cryopreservation and storage for both male and female members when a medically necessary treatment may cause iatrogenic infertility. Member cost share for fertility preservation services is based on provider type and service rendered.
- 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](https://le.anthem.com/pdf?x=CA_LG_HMO)
- For additional information on this plan, please visit [sbc.anthem.com](http://sbc.anthem.com) to obtain a Summary of Benefit Coverage.