Your summary of benefits

Anthem® Blue Cross

Your Plan: Anthem Classic HMO 30/50/500 admit/250 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
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.*	$0 person	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.*	$2,500 single / $5,000 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	$30 copay per visit	Not covered
Specialist Care Visit	$50 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
Prenatal and Post-natal Care	$30 copay per visit	Not covered
Other Practitioner Visits:		
Retail Health Clinic	$30 copay per visit	Not covered
Preferred On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	$10 copay per visit	Not covered
Chiropractic Services *Coverage is limited to 60 days per benefit period. Applies to In-Network. Limit is combined across professional visits and outpatient facilities. Limit is combined for chiropractic visits and rehabilitative and habilitative physical, occupational, and speech therapy.*	$30 copay per visit	Not covered
Acupuncture	$30 copay per visit	Not covered
Other Services in an Office:		
Allergy Testing	$30 copay per visit	Not covered
Chemo/Radiation Therapy	$50 copay per visit	Not covered
Hemodialysis	$50 copay per visit	Not covered
Prescription Drugs *For the drugs itself dispensed in the office through infusion/injection. Maximum of $150 member per visit member cost share per drug.*	30% coinsurance	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
Diagnostic Services		
Lab:		
Office	No charge	Not covered
Freestanding Lab	No charge	Not covered
Outpatient Hospital	No charge	Not covered
X-Ray:		
Office	No charge	Not covered
Freestanding Radiology Center	No charge	Not covered
Outpatient Hospital	No charge	Not covered
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office	$100 copay per service	Not covered
Freestanding Radiology Center	$100 copay per service	Not covered
Outpatient Hospital	$100 copay per visit	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
Emergency and Urgent Care		
Urgent Care (Office Setting)	$30 copay per visit	Covered as In-Network
Emergency Room Facility Services *Copay waived if admitted.*	$100 copay per visit	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	Covered as In-Network
Ambulance (Air and Ground)	$100 copay per trip	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	$30 copay per visit	Not covered
Facility visit:		
Facility Fees	No charge	Not covered
Doctor Services	No charge	Not covered
Outpatient Surgery		
Facility Fees:		
Hospital	$250 copay per visit	Not covered
Freestanding Surgical Center	$250 copay per visit	Not covered
Doctor and Other Services:		

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Hospital/Freestanding Surgical Center	No charge	Not covered
Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)		
Facility fees (for example, room & board)	$500 copay per admission	Not covered
Doctor and other services	No charge	Not covered
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 100 visits per benefit period. Applies to In-Network.*	$30 copay per visit	Not covered
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for physical therapy, occupational therapy and speech therapy is limited to 60 days combined per benefit period. Chiropractic visits count towards your physical, occupational, and speech therapy limits. Applies to In-Network. Limit is combined across professional visits and outpatient facilities.*	$30 copay per visit	Not covered
Outpatient Hospital *Coverage for physical therapy, occupational therapy and speech therapy is limited to 60 days combined per benefit period. Chiropractic visits count towards your physical, occupational, and speech therapy limits. Applies to In-Network. Limit is combined across professional visits and outpatient facilities.*	$50 copay per visit	Not covered
Habilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for physical therapy, occupational therapy and speech therapy is limited to 60 days combined per benefit period. Chiropractic visits count towards your physical, occupational, and speech therapy limits.*	$30 copay per visit	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
Applies to In-Network. Limit is combined across professional visits and outpatient facilities.		
Outpatient Hospital *Coverage for physical therapy, occupational therapy and speech therapy is limited to 60 days combined per benefit period. Chiropractic visits count towards your physical, occupational, and speech therapy limits. Applies to In-Network. Limit is combined across professional visits and outpatient facilities.*	$50 copay per visit	Not covered
Cardiac rehabilitation		
Office	$30 copay per visit	Not covered
Outpatient Hospital	$50 copay per visit	Not covered
Skilled Nursing Care (in a facility) *Coverage is limited to 100 days per benefit period. Applies to In-Network.*	No charge	Not covered
Hospice	No charge	Not covered
Durable Medical Equipment	20% 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	Not applicable	Not applicable
Pharmacy Out of Pocket	Combined with medical out of pocket maximum	Combined with medical out of pocket maximum
Prescription Drug Coverage *This plan uses an Essential Drug List.* *Drugs not on the list are not covered. This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.*		
Tier 1a - Typically Lower Cost Generic *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. No coverage for non-formulary drugs.*	$5 copay per prescription (retail) and $12.50 copay per prescription (home delivery)	50% coinsurance up to $250 per prescription (retail) and Not covered (home delivery)
Tier 1b - Typically Generic *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. No coverage for non-formulary drugs.*	$15 copay per prescription (retail) and $37.50 copay per prescription (home delivery)	50% coinsurance up to $250 per prescription (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. No coverage for non-formulary drugs.*	$30 copay per prescription (retail) and $90 copay per prescription (home delivery)	50% coinsurance up to $250 per prescription (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. No coverage for non-formulary drugs.*	$50 copay per prescription (retail) and $150 copay per prescription (home delivery)	50% coinsurance up to $250 per prescription (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	30% coinsurance up to $250 per	50% coinsurance up to $250 per prescription (retail)

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Covers up to a 30 day supply (retail pharmacy). Classified specialty drugs must be obtained through our Specialty Pharmacy Program and are subject to the terms of the program. No coverage for non-formulary drugs.	prescription (retail and home delivery)	and Not covered (home delivery)

Your summary of benefits

Notes:

- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both 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.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- For additional information on this plan, please visit www.sbc.anthem.com to obtain a "Summary of Benefits and Coverage".
- Your plan requires selection of a Primary Care Physician. Your plan requires a referral from your Primary Care Physician for select covered services.
- In Network and Non Network pharmacy deductibles are combined. Satisfying one helps satisfy the other. Pharmacy deductibles are included in the annual out-of-pocket maximums.
- Infertility services are not included in the out of pocket amount.
- Certain drugs require pre-authorization approval to obtain coverage.
- 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.
- 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.
- 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.
- Freestanding Lab and Radiology Center is defined as services received in a non-hospital based facility.
- 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.
- 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.
- Respite Care limited to 5 visits per lifetime.
- Skilled Nursing Facility day limit does not apply to mental health and substance abuse.
- Supply limits for certain drugs may be different, go to Anthem website or call customer service.
- 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).

- 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.

Get help in your language

Language Assistance Services

Curious to know what all this says? We would be too. Here's the English version:
IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (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
IMPORTANTE: ¿Puede leer esta carta? De lo contrario, podemos hacer que alguien lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721. (TTY/TDD: 711)

Arabic
مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاستعانة بشخص ما ليساعدك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم1-888-254-2721 (TTY/TDD:711).

Armenian
ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող ենք նաև այս նամակը Ձեզ գրավոր տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-888-254-2721 հեռախոսահամարով: (TTY/TDD: 711)

Chinese
重要事項：您能看懂這封信函嗎？如果您看不懂，我們能夠找人協助您。您有可能可以獲得以您的語言而寫的本信函。如需免費協助，請立即撥打1-888-254-2721。(TTY/TDD: 711)

Farsi
مهم: آیا می‌توانید این نامه را بخوانید؟ اگر نمی‌توانید، می‌توانیم شخصی را به شما معرفی کنیم تا در خواندن این نامه شما را کمک کند. همچنین می‌توانید این نامه را به صورت مکتوب به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، همین حالا با شماره 1-888-254-2721 تماس بگیرید.(TTY/TDD:711)

Hindi
महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम आपको इसे पढ़ने में मदद करने के लिए किसी को उपलब्ध करा सकते हैं। आप यह पत्र अपनी भाषा में लिखवाने में भी सक्षम हो सकते हैं। निःशुल्क मदद के लिए, कृपया 1-888-254-2721 पर तुरंत कॉल करें। (TTY/TDD: 711)

Hmong
TSEEM CEEB: Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwm tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

Japanese

重要：この書簡を読めますか？もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたものを入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。1-888-254-2721 (TTY/TDD: 711)

Khmer
សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ យើងអាចឲ្យនរណាម្នាក់អានវាជូនអ្នក។ អ្នកក៏អាចទទួលលិខិតនេះដោយសរសេរជាភាសារបស់អ្នកផងដែរ។ ដើម្បីទទួលជំនួយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅលេខ 1-888-254-2721។ (TTY/TDD: 711)

Korean
중요: 이 서신을 읽으실 수 있으십니까? 읽으실 수 없을 경우 도움을 드릴 사람이 있습니다. 귀하가 사용하는 언어로 쓰여진 서신을 받으실 수도 있습니다. 무료 도움을 받으시려면 즉시 1-888-254-2721로 전화하십시오. (TTY/TDD: 711)

Punjabi
ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸ□ ਇਹ ਪੱਤਰ ਪੜਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹ□, ਤਾਂ ਅਸ□ ਇਸ ਨੂੰ ਪੜਹ੍ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸ□ ਸ਼ਾਇਦ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵਬੀ ਪਰ੍ਾਪ੍ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਫੈਰਨ 1-888-254-2721 ਤੇ ਕਾਲ਼ ਕਰੋ। (TTY/TDD: 711)

Russian
ВАЖНО. Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

Tagalog
MAHALAGA: Nababasa ba ninyo ang liham na ito? Kung hindi, may taong maaaring tumulong sa inyo sa pagbasa nito. Maaari ninyo ring makuha ang liham na ito nang nakasulat sa ginagamit ninyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai
หมายเหตุสำคัญ: ท่านสามารถอ่านจดหมายฉบับนีหรือไม่ หากท่านไม่สามารถอ่านจดหมายฉบับนี เราสามารถจัดหาเจ้าหน้าทีมาอ่านให้ท่านฟังได้ ท่านยังอาจให้เจ้าหน้าทีช่วยเขียนจดหมายในภาษาของท่านอีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อทีหมายเลข 1-888-254-2721 (TTY/TDD: 711)

Vietnamese
QUAN TRỌNG: Quý vị có thể đọc thư này hay không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc thư này. Quý vị cũng có thể nhận thư này bằng ngôn ngữ của quý vị. Để được giúp đỡ miễn phí, vui lòng gọi ngay số 1-888-254-2721. (TTY/TDD: 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/TDD: 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.