Your summary of benefits

Anthem BlueCross

Anthem Blue Cross

Your Plan: ALADS Custom 2021 HMO

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. Benefits are subject to all terms, conditions, limitations, and exclusions of the EOC.

Covered Medical Benefits	Your cost if you use an In-Network Provider	Your 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	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.*	$500 single / $1,500 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	$10 copay per visit	Not covered
Specialist care visit	$10 copay per visit	Not covered
Prenatal and Post-natal Care	$10 copay per visit	Not covered
Other practitioner visits:		
LiveHealth Online	$10 copay per visit	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.*	$10 copay per visit	Not covered
Acupuncture	$10 copay per visit	Not covered

Your summary of benefits

Covered Medical Benefits	Your cost if you use an In-Network Provider	Your cost if you use a Non-Network Provider
Other services in an office:		
Allergy testing and treatment *Includes serums*	$10 copay per visit	Not covered
Chemo/radiation therapy	No charge	Not covered
Hemodialysis	No charge	Not covered
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 *Costs may vary by site of service.*	No charge	Not covered
Freestanding Radiology Center *Costs may vary by site of service.*	No charge	Not covered
Outpatient Hospital *Costs may vary by site of service.*	No charge	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.*	$25 copay per visit	Covered as In-Network
Emergency room doctor and other services	No charge	Covered as In-Network
Ambulance (air and ground)	No charge for ground and air	Covered as In-Network

Your summary of benefits

Covered Medical Benefits	Your cost if you use an In-Network Provider	Your cost if you use a Non-Network Provider
Urgent Care (office setting) *Copay waived if admitted. Costs may vary by site of service.*	$10 copay per visit	Covered as In-Network
Outpatient Surgery		
Facility fees:		
Hospital	No charge	Not covered
Freestanding Surgical Center	No charge	Not covered
Doctor and other services	No charge	Not covered
Hospital Stay (all inpatient stays including maternity)		
Facility fees (for example, room & board)	No charge	Not covered
Doctor and other services	No charge	Not covered
Recovery & Rehabilitation		
Home health care	$10 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. Habilitation visits count towards your rehabilitation limit.*	$10 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. Costs may vary by site of service. Habilitation visits count towards your rehabilitation limit.*	No charge	Not covered
Habilitation services *(Habilitation visits count towards your rehabilitation limit.)* Office	No charge	Not covered
Outpatient hospital	No charge	Not covered
Cardiac rehabilitation		
Office *Costs may vary by site of service.*	$10 copay per visit	Not covered

Your summary of benefits

Covered Medical Benefits	Your cost if you use an In-Network Provider	Your cost if you use a Non-Network Provider
Outpatient hospital *Costs may vary by site of service.*	No charge	Not covered
Skilled nursing care (in a facility) *Coverage for In-Network Provider is limited to 100 day limit per benefit period.*	No charge	Not covered
Hospice	No charge	Not covered
Durable Medical Equipment *Hearing aids benefit is available for one hearing aid per ear every three years.*	No charge	Not covered
Prosthetic Devices	No charge	Not covered
Refractive Eye Surgeries *Including astigmatic keratotomy, lamellar kerotoplasy and laser procedures for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia), hyperopia (farsightedness) or astigmatism. Limited to a lifetime benefit of $1,500/eye.*	No charge	Not covered

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.
- 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 five 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.
- Mental Health and Substance Abuse benefits are covered by The Holman Group.
- 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.