Your summary of benefits

Anthem BlueCross

Anthem Blue Cross ACWA JPIA – C00361

Your Plan: 2021 HMO Value Plan (0KGJ)

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	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	N/A
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	N/A
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	Not covered
Primary care visit to treat an injury or illness	$30 copay per visit	Not covered
Specialist care visit	$30 copay per visit	Not covered
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.*	No charge	Not covered

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Covered Medical Benefits	Your cost if you use an In-Network Provider	Your cost if you use a Non-Network Provider
Chiropractor services *Coverage for In-Network Provider is limited to 60 visits per illness or injury. Limit is combined with Physical Therapy, Physical Medicine, and Occupational Therapy. Physician referral is required.*	$30 copay per visit	Not covered
Chiropractic care benefits also available through the American Specialty Health Plans Chiropractic network. Limited to 30 visits per year. Appliances limited to $50 per year. Physician referral is not required.	$10 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	$30 copay per visit	Not covered
Hemodialysis	$30 copay per visit	Not covered
Prescription drugs *For the drug itself, dispensed in an office through infusion/injection*	30% coinsurance up to $150 per visit	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	$100 copay per test	Not covered
Freestanding Radiology Center	$100 copay per test	Not covered
Outpatient Hospital	$100 copay per test	Not covered

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Covered Medical Benefits	Your cost if you use an In-Network Provider	Your cost if you use a Non-Network Provider
Emergency and Urgent Care		
Emergency room facility services *This is for the hospital/facility charge only.* *Copay waived if admitted.*	$150 copay per visit	Covered as In-Network
Emergency room doctor and other services	No charge	Covered as In-Network
Ambulance (air and ground)	$50 copay per trip for ground and air	Covered as In-Network
Urgent Care (office setting)	$30 copay per visit	(Out of service area) 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
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, mental / behavioral health, and substance abuse)		
Facility fees (for example, room & board)	$250 copay per admission	Not covered
Doctor and other services	No charge	Not covered

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Covered Medical Benefits	Your cost if you use an In-Network Provider	Your cost if you use a Non-Network Provider
Recovery & Rehabilitation		
Home health care *Coverage for In-Network Provider is limited to 100 visit limit per benefit period.*	$30 copay per visit	Not covered
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for In-Network Provider is limited to 60 consecutive days per illness or injury for Physical, Occupational and Speech Therapy combined. Limit is combined with 60 Chiropractic visit limit.*	$30 copay per visit	Not covered
Outpatient hospital *Coverage for In-Network Provider is limited to 60 consecutive days per illness or injury for Physical, Occupational and Speech Therapy combined. Limit is combined with 60 Chiropractic visit limit.*	$30 copay per visit	Not covered
Habilitation services *Habilitation visits count towards your rehabilitation limit.* Office & Outpatient hospital	$30 copay per visit	Not covered
Cardiac rehabilitation		
Office	$30 copay per visit	Not covered
Outpatient hospital	$30 copay per visit	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	No charge	Not covered
Prosthetic Devices	No charge	Not covered

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Covered Prescription Drug Benefits	Your cost if you use an In-Network Pharmacy	Your cost if you use a Non-Network Pharmacy
Pharmacy Deductible *In-Network Pharmacy and Non-Network Pharmacy deductibles are combined. Satisfying one helps satisfy the other.*	$100/member; $300/family	$100/member; $300/family
Pharmacy Out of Pocket	$4,100/ member; $8,200/family	None
Prescription Drug Coverage *This plan uses a National Drug List. Drugs not on the list are not covered. You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days.*		
Preventive Pharmacy		
Preventive Immunization	$0 copay (retail only)	50% coinsurance up to $250 per prescription (retail only)
Female oral contraceptive *Generic and Single Source brand*	$0 copay (retail only)	50% coinsurance up to $250 per prescription (retail only)
Generic Drugs *Member pays the retail pharmacy copay plus 50% for out of network. Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).*	$5 copay per prescription (retail only) and $10 copay per prescription (home delivery only)	50% coinsurance up to $250 per prescription (retail only)
Brand Name Formulary Drugs *Member pays the retail pharmacy copay plus 50% for out of network. Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).*	$20 copay per prescription (retail only) and $40 copay per prescription (home delivery only)	50% coinsurance up to $250 per prescription (retail only)
Brand Name Non-Formulary Drugs *Certain drugs require preauthorization approval to obtain coverage. Member pays the retail pharmacy copay plus 50% for out of network. Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program)*	$50 copay per prescription (retail only) and $100 copay per prescription (home delivery only)	50% coinsurance up to $250 per prescription (retail only)

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Covered Prescription Drug Benefits	Your cost if you use an In-Network Pharmacy	Your cost if you use a Non-Network Pharmacy
Self-Administered Injectable Drugs (except insulin) *Covers up to a 30 day supply (retail pharmacy) and up to 90 day supply (home delivery).*	20% coinsurance up to $100 per prescription (retail only) and 20% coinsurance up to $200 per prescription (home delivery only)	50% coinsurance up to $250 per prescription (retail only)
Specialty Pharmacy Program *Certain specialty pharmacy drugs may be obtained through the specialty pharmacy program (limited to a 30-day supply). Please contact the customer service on the back of your ID card to see if your drug is on the specialty pharmacy program or obtain a list at anthem.com.*	Applicable copay applies	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 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
- When using non-network pharmacy, members are responsible for in-network pharmacy copay plus50% of the remaining prescription drug maximum allowed amount & costs in excess of the prescription drug maximum allowed amount. Members will pay upfront and submit a claim form.
- Preferred Generic Program: If a member requests a brand name drug when a generic drug version exists, the member pays the generic drug copay plus the difference in cost between the prescription drug maximum allowed amount for the generic drug and the brand name drug dispensed, but not more than 50% of our average cost of that type of prescription drug. The Preferred Generic Program does not apply when the physician has specified "dispense as written" (DAW) or when it has been determined that the brand name drug is medically necessary for the member. In such case, the applicable copay for the dispensed drug will apply.

- Supply limits for certain drugs may be different, go to Anthem website or call customer service.
- Certain drugs require pre-authorization approval to obtain coverage.
- 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 www.acwajpia.com to obtain a Summary of Benefit Coverage.