Traditional HMO - 1/1/2020-12/31/2020

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 proposed benefit summary is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care

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 services provided under the "ReadyAccess" program, OB/GYN services received within the member's medical group/IPA, and services for all mental and nervous disorders and substance abuse. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Annual copay maximum: Individual $3,000; Family $6,000
The following copay does not apply to the annual copay maximum: for infertility services. After an annual copay maximum is met for medical and prescription drugs during a calendar year, the individual member or family will no longer be required to pay a copay or coinsurance for medical and prescription drug covered expenses for the remainder of that year. The member remains responsible for non-covered expenses infertility services.

Covered Services	Per Member Copay
Inpatient Medical Services	
➢ Semi-private room or private room if medically necessary; meals and special diets; services and supplies	$100/admission
➢ Special care units	No copay
➢ Operating room and special treatment rooms	No copay
➢ Nursing care	No copay
➢ Drugs, medications & oxygen administered in the hospital	No copay
➢ Blood & blood products	No copay
Outpatient Medical Services *(hospital care other than emergency room services)*	No copay
Ambulatory Surgical Center	
➢ Outpatient surgery & supplies	No copay
Skilled Nursing Facility *(limited to 100 days/calendar year; limit does not apply to mental health and substance abuse)*	
➢ All necessary services & supplies *(excluding take-home drugs)*	No copay
Hospice Care *(Inpatient or outpatient services; family bereavement services)*	No copay
Home Health Care	
➢ Home visits when ordered by primary care physician *(limited to 100 visits/calendar year; one visit by a home health aide equals four hours or less)*	No copay
Physician Medical Services	
➢ Office & home visits	$20/visit
➢ LiveHealth Online visits	$20/visit
➢ Hospital visits	No copay
➢ Skilled nursing facility visits	No copay
➢ Specialists & consultants	$20/visit
Short-Term Physical, Occupational, or Speech Therapy, or Chiropractic Care when Ordered by the Primary Care Physician *(limited to a 60-day period of care after an illness or injury; additional visits available when approved by the medical group)*	$20/visit
Acupuncture	$20/visit

Covered Services	Per Member Copay
Surgical Services	
➢ Surgeon & surgical assistant	No copay
➢ Anesthesiologist or anesthetist	No copay
General Medical Services	
➢ Diagnostic X-ray & laboratory procedures *(including mammograms, pap smears, & prostate cancer screening)*	No copay
➢ Radiation therapy, chemotherapy & hemodialysis treatment	No copay
➢ Prosthetic devices	No copay
➢ Durable medical equipment including hearing aids (*hearing aids benefit is available for one hearing aid per ear every three years; breast pump and supplies are covered under preventive care at no charge*)	No copay
Preventive Care Services	
Preventive Care Services including*, physical exams, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunizations, health education, intervention services, HIV testing), and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration.	No copay
*This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.	
Health Education and Wellness Programs	
➢ Specified immunizations	No copay
➢ Allergy testing & treatment *(including serums)*	$20/visit
➢ Selected health education programs	No copay
Emergency Care	
In Area *(within 20 miles of medical group)* **and Out of Area**	
➢ Physician & medical services	No copay
➢ Outpatient hospital emergency room services	$50/visit *(waived if admitted)*
➢ Inpatient hospital services	No copay
Ambulance Services	
➢ Ground or air ambulance transportation when medically necessary, including medical services & supplies	No copay
Pregnancy and Maternity Care	
Office Visits	
➢ Prenatal & postnatal care	$20/visit
➢ Complications of pregnancy or abortions	$20/visit
Normal Delivery or Cesarean Section, including:	
➢ Inpatient hospital & ancillary services	$100/admission
➢ Routine nursery care	No copay
➢ Physician services *(inpatient only)*	No copay
Complication of Pregnancy or Abortion, including:	
➢ Inpatient hospital & ancillary services	$100/admission
➢ Outpatient hospital services	No copay
➢ Physician services *(inpatient only)*	No copay
Abortions *(including prescription drug for abortion [mifepristone])*	No copay
Genetic Testing of Fetus	No copay

Covered Services	Per Member Copay
Family Planning Services	
➢ Infertility studies & tests	50% of covered expense[1]
➢ Female Sterilization (*including tubal ligation and counseling/consultation*	No copay
➢ Male Sterilization	No copay
➢ Counseling & consultation	$20/visit
Organ and Tissue Transplant	
➢ Inpatient Care	No copay
➢ Physician office visits *(including primary care, specialty care & consultants)*	$20/visit
Mental or Nervous Disorders and Substance Abuse	
➢ Inpatient facility care *(subject to utilization review; waived for emergency admissions)*	$100/admission
➢ Inpatient physician visits	$20/visit
➢ Outpatient facility care	No copay
➢ Physician office visits (Behavioral Health treatment for Autism or Pervasive Development disorders require pre-service review)	$20/visit
Smoking Cessation Program	No copay

[1] Not applicable to the annual copay maximum

This Summary of Benefits is a brief review of benefits. Once enrolled, members will receive the Combined Evidence of Coverage and Disclosure Form, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.

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