

Individual Policy Comparison

for current Anthem Blue Cross
members with special options

This is intended to be a brief overview of benefits and services and is not intended to be a legal contract. The entire provisions of benefits, limitations and exclusions can be found in the Policy. In the event of a conflict between the Policy and this overview, the terms of the Policy will prevail.

This summary of benefits complies 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.

ClearProtection Plus, CoreGuard Plus, SmartSense Plus, Premier Plus, Lumenos HSA, Lumenos HSA Plus and PPO Share 1000/5000 are offered by Anthem Blue Cross Life and Health Insurance Company. Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. © ANTHEM and LUMENOS are registered trademarks of Anthem Insurance Companies, Inc. © SmartSense and the Blue Cross name and symbol are registered marks of the Blue Cross Association.

Individual Policy Comparison (Policies filed with the California Department of Insurance)

Premiums will vary based on the particular policy/plan. You may determine the premium for a particular policy/plan by calling 1-866-636-8991.

All benefits are after the deductible unless otherwise stated.	SmartSense® Plus 1000/2000/3500/6000 Standard Rx		SmartSense® Plus 1000/2000/3500/6000 Upgrade Rx		Clear Protection™ Plus 1000/3300/5000		CoreGuard™ Plus 750/1500/2500/3500/5000/7500		CoreGuard™ Plus 10000		Premier Plus 1000/1500/2500/3500/5000/6000		Lumenos® HSA Plus 3000/4500/5950		Lumenos® HSA Plus 3500/5500/7500/11900		Lumenos® HSA non-maternity		Lumenos® HSA maternity		Tonik® 5000		PPO Share 1000		PPO Share 5000		
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	
Annual Deductible: • Single only contract • 2 member max: entire family deductible satisfied once 2 members meet deductible • Aggregate: 1 or more members contribute to satisfy family deductible • Embedded: 2 or more members contribute to satisfy family deductible	Single: \$1000/\$2000/\$3500/\$6000 Family, embedded: \$2000/\$4000/\$7000/\$12000	Single: \$1000/\$2000/\$3500/\$6000 Family, embedded: \$2000/\$4000/\$7000/\$12000	Single: \$1000/\$2000/\$3500/\$6000 Family, embedded: \$2000/\$4000/\$7000/\$12000	Single: \$1000/\$2000/\$3500/\$6000 Family, embedded: \$2000/\$4000/\$7000/\$12000	Single: \$1000/\$3300/\$5000 Family, embedded: \$2000/\$6600/\$10000	Single: \$750/\$1500/\$2500/\$3500/\$5000/\$7500 Family, embedded: \$1500/\$3000/\$5000/\$7000/\$10000/\$15000	Single: \$750/\$1500/\$2500/\$3500/\$5000/\$7500 Family, embedded: \$1500/\$3000/\$5000/\$7000/\$10000/\$15000	Single: \$10000 Family, embedded: \$20000	Single: \$10000 Family, embedded: \$20000	Single: \$1000/\$1500/\$2500/\$3500/\$5000/\$6000 Family, embedded: \$2000/\$3000/\$5000/\$7000/\$10000/\$12000	Single: \$1000/\$1500/\$2500/\$3500/\$5000/\$6000 Family, embedded: \$2000/\$3000/\$5000/\$7000/\$10000/\$12000	Single: \$3000/\$4500/\$5950 Single: \$3000/\$4500/\$5950	Single: \$3500/\$5500 Family, embedded: \$7500/\$11900	Family, aggregate: \$3500/\$5500 Family, embedded: \$7500/\$11900	Family, aggregate: \$3500/\$5500 Family, embedded: \$7500/\$11900	Single: \$1500 Family, aggregate: \$3000	Single: \$5000 Family, aggregate: \$10000	Single: \$5000 (in-network and out-of-network combined)	Single: \$5000 (in-network and out-of-network combined)	\$1000, 2 member max (in-network and out-of-network combined)	\$5000, 2 member max (in-network and out-of-network combined)	None	None	None	None	None	None
Lifetime Maximum	None		None		None		None		None		None		None		None		None		None		None		None		None		
Annual Out-of-Pocket Maximum (in addition to deductible)	Single: \$3500 Family, embedded: \$7000	Single: \$7500 Family, embedded: \$15000	Single: \$3500 Family, embedded: \$7000	Single: \$7500 Family, embedded: \$15000	Single: \$3500 Family, embedded: \$7000	Single: \$3500 Family, embedded: \$7000	Single: \$3500 Family, embedded: \$7000	Single: \$7500 Family, embedded: \$15000	Single: \$4500 Family, embedded: \$9000	Single: \$7500 Family, embedded: \$15000	0% after deductible	Single: \$3000/\$4500/\$5950	0% after deductible	Family, aggregate: \$3500/\$5500 Family, embedded: \$7500/\$11900	Single: \$3500 Family: \$7000	Single: \$8500 Family: \$17000	\$0	Single: \$5000 Family: \$10000	0% after deductible	Single: \$10000	\$4000, 2 member max (in-network and out-of-network combined)	\$2500, 2 member max (in-network and out-of-network combined)	None	None	None	None	
Doctor's Office Visits	\$30 copay for 3 OV; then 30% coinsurance after deductible	50% of negotiated fee plus all excess charges	\$30 copay for 3 OV; then 30% coinsurance after deductible	50% of negotiated fee plus all excess charges	\$40 copay, deductible waived for 2 office visits then 0% after OOP met	No office visit benefit until OOP max met, then 50% of negotiated fee, plus all excess charges	50%	70% of negotiated fee plus all excess charges	0% after deductible	30% of negotiated fee plus all excess charges	\$30 copay for primary doctor; \$50 copay for specialist (deductible waived for both)	50% of negotiated fee plus all excess charges	0% after deductible	40% of negotiated fee plus all excess charges	30%	50% of negotiated fee plus all excess charges	0%	30% of negotiated fee plus all excess charges	\$20 visits, 4 visits/year (additional visits covered in full after annual deductible)	50% of negotiated fee plus all excess charges	30% deductible waived	50% of negotiated fee plus all excess charges (deductible waived)	\$40 copay (deductible waived)	50% of negotiated fee plus all excess charges			
Professional Services	30%	50% of negotiated fee plus all excess charges	30%	50% of negotiated fee plus all excess charges	Inpatient: 40% Coinsurance Outpatient: 100% negotiated fee; then 0% coinsurance after OOP max met	Inpatient: 50% Coinsurance Outpatient: 100% Coinsurance; then 50% coinsurance after OOP max met	50%	70% of negotiated fee plus all excess charges	0% after deductible	30% of negotiated fee plus all excess charges	25%	50% of negotiated fee plus all excess charges	0% after deductible	40% of negotiated fee plus all excess charges	30%	50% of negotiated fee plus all excess charges	0%	30% of negotiated fee plus all excess charges	0% after deductible	50% of negotiated fee plus all excess charges	30%	50% of negotiated fee plus all excess charges	30%	50% of negotiated fee plus all excess charges			
Hospital Inpatient	30%	All charges except \$650 per day	30%	All charges except \$650 per day	40%	All charges except \$650 per day	50% Coinsurance PLUS \$500 Facility Copay per day up to the first 3 days (Facility copay applies to 750/1500/2500 only)	70% Coinsurance PLUS \$500 Facility Copay per day up to the first 3 days (Facility copay applies to 750/1500/2500 only)	0% after deductible	30% of negotiated fee plus all excess charges	25%	50% of negotiated fee plus all excess charges	0% after deductible	40% of negotiated fee plus all excess charges	30%	All charges except \$650 per day	0%	All charges except \$650 per day	0% after deductible	All charges except \$650 per day	30%	All charges except \$650 per day	30%	All charges except \$650 per day			
Hospital Outpatient	30%	All charges except \$380 per day	30%	All charges except \$380 per day	Surgery: 40% Coinsurance Other Services: 100% negotiated fee; then 0% coinsurance after OOP max met	All charges except \$380 per day	50% Coinsurance PLUS \$200 Facility Copay per admission (Facility copay applies to 750/1500/2500 only)	70% Coinsurance PLUS \$200 Facility Copay per admission (Facility copay applies to 750/1500/2500 only)	0% after deductible	30% of negotiated fee plus all excess charges	25%	50% of negotiated fee plus all excess charges	0% after deductible	40% of negotiated fee plus all excess charges	30%	All charges except \$380 per day	0%	All charges except \$380 per day	0% after deductible	All charges except \$380 per day	30%	All charges except \$380 per day	30%	All charges except \$380 per day			
Emergency Services (\$100 copay applies for each visit; waived if admitted as inpatient)	30%	30% of negotiated fee plus all excess charges	30%	30% of negotiated fee plus all excess charges	40%	40% of negotiated fee plus all excess charges	50% (\$100 ER copay does not apply)	50% of negotiated fee plus all excess charges (\$100 ER copay does not apply)	0% after deductible (\$100 ER copay does not apply)	0% after deductible of negotiated fee plus all excess charges (\$100 ER copay does not apply)	25% (\$100 ER copay does not apply)	25% of negotiated fee plus all excess charges (\$100 ER copay does not apply)	0% after deductible (\$100 ER copay does not apply)	0% of negotiated fee plus all excess charges (\$100 ER copay does not apply)	0% after deductible (\$100 ER copay does not apply)	0% of negotiated fee plus all excess charges (\$100 ER copay does not apply)	30%	30% of negotiated fee plus all excess charges	0% after deductible	0% after deductible	30%	30% of negotiated fee plus all excess charges	30%	30% of negotiated fee plus all excess charges			
Maternity	Not covered		Not covered		Not covered		Not covered		Not covered		Not covered		Not covered		Not covered		0% 30% of negotiated fee plus all excess charges		Not covered		30%	50% of negotiated fee plus all excess charges	30%	50% of negotiated fee plus all excess charges			
Preventive Care	0% not subject to deductible Healthy Check Center \$0	50% of negotiated fee plus all excess charges	0% not subject to deductible Healthy Check Center \$0	50% of negotiated fee plus all excess charges	0% not subject to deductible Healthy Check Center \$0	50% of negotiated fee plus all excess charges	0% not subject to deductible Healthy Check Center \$0	70% of negotiated fee plus all excess charges	0% not subject to deductible Healthy Check Center \$0	30% of negotiated fee plus all excess charges	0% not subject to deductible Healthy Check Center \$0	50% of negotiated fee plus all excess charges	0% not subject to deductible	40% of negotiated fee plus all excess charges	0% not subject to deductible	50% of negotiated fee plus all excess charges	0% not subject to deductible	30% of negotiated fee plus all excess charges	0% not subject to deductible Healthy Check Center \$0	50% of negotiated fee plus all excess charges	0% not subject to deductible Healthy Check Center \$0	50% of negotiated fee plus all excess charges	0% not subject to deductible Healthy Check Center \$0	50% of negotiated fee plus all excess charges			
Prescription Drug Benefits	Generic: \$15 copay Brand: \$40 copay after \$750 deductible Non-formulary: \$60 copay after \$750 deductible Specialty: 25% coins; up to \$2500 after \$750 deductible	Not covered	Generic: \$15 copay Brand: \$40 copay after \$750 deductible Non-formulary: \$60 copay after \$500 deductible Specialty: 25% coins; up to \$2500 after \$500 deductible	Not covered	Generic: \$15 copay Brand: \$40 copay after \$750 deductible Non-formulary: \$60 copay after \$750 deductible Specialty: 25% coins; up to \$2500 after \$750 deductible	Not covered	Generic: \$15 copay Brand: \$40 copay after \$750 deductible Non-formulary: \$60 copay after \$750 deductible Specialty: 25% coins; up to \$2500 after \$750 deductible	Not covered	Generic: \$15 copay Brand: \$40 copay after \$750 deductible Non-formulary: \$60 copay after \$750 deductible Specialty: 25% coins; up to \$2500 after \$750 deductible	Not covered	Generic: \$15 copay Brand: \$40 copay after \$750 deductible Non-formulary: \$60 copay after \$750 deductible Specialty: 25% coins; up to \$2500 after \$750 deductible	Not covered	0% after med deductible 40% of drug limited fee schedule plus all excess charges	0% after med deductible 40% of drug limited fee schedule plus all excess charges	30% after med deductible 50% of drug limited fee schedule plus all excess charges	0% after med deductible 30% of drug limited fee schedule plus all excess charges	0% after med deductible 30% of drug limited fee schedule plus all excess charges	Generic: \$15 copay 50% of drug limited fee schedule and all excess charges plus the copay/coinsurance as stated for in-network benefits	Generic: \$15 copay 50% of drug limited fee schedule and all excess charges plus the copay/coinsurance as stated for in-network benefits; subject to the \$250 deductible	Generic: \$10 copay Brand: \$30 copay after \$250 deductible Non-formulary: 50% after \$250 deductible	50% of drug limited fee schedule and all excess charges plus the copay/coinsurance as stated for in-network benefits; subject to the \$250 deductible	Generic: \$15 copay Brand: \$35 copay after \$750 deductible Non-formulary: 50% after \$750 deductible	50% of drug limited fee schedule and all excess charges plus the copay/coinsurance as stated for in-network benefits; subject to the \$750 deductible				