COVERED SERVICES	ANTHEM BLUE CROSS CALIFORNIACARE MEDICAL PLAN IN-NETWORK BENEFITS	
Annual Deductible	None	
Annual Out-Of-Pocket Maximum*	$500/person; $1,500/family	
Lifetime Maximum Benefit	Unlimited	
PREVENTIVE CARE		
Immunization	No charge	
Periodic Health Evaluations	No charge	
MEDICALLY NECESSARY CARE		
Ambulance	No charge	
Doctor Office Visit	$10 copay/visit	
Emergency Room	$25 copay/visit (waived if admitted)	
Hospital Care	No charge	
Maternity Office Visit	$10 copay/visit	
Outpatient Surgery	No charge	
X-Ray & Lab Tests	No charge	
Prescription Drugs	Retail Pharmacy (30-day supply): $5 copay for generic $15 copay for brand Mail order (90-day supply): $5 copay for generic $5 copay for brand	
MENTAL HEALTH CARE - *Provided by The Holman Group*		
Mental Health Outpatient	$10 copay/visit	
Mental Health Inpatient	No charge	
VISION CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
The vision benefits provided by Vision Service Plan (VSP), are included in the Anthem Blue Cross CaliforniaCare Medical Plan at no additional cost.		
Eye Exam (Covered every 12 months)	$0 copay	Up to $50 allowance
Standard Lenses (Covered every 24 months)	$0 copay	Up to $50 allowance
Frames (Covered every 24 months)	$120 allowance, then 20% off	Up to $70 allowance
Contacts (Covered every 24 months, instead of glasses)	$120 allowance	Up to $105 allowance
OTHER PLANS BENEFITS	**IN-NETWORK BENEFITS**	
Self-Referred Chiropractic Care	$10 copay/visit (up to 35 visits/calendar year)	
Home Health Care	$10 copay/visit	
Hospice Care	No charge	
Physical Therapy	$10 copay/visit (up to 60 days/calendar year)	
Skilled Nursing Facility	No charge (up to 100 days/calendar year)	

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*****Annual out-of-pocket maximum applies to copayments for medical and mental health provider services listed above and excludes charges for infertility services, premiums, balance-billing, and services this plan doesn't cover.

ANTHEM BLUE CROSS CALIFORNIACARE PREMIER DENTAL PLAN		
COVERED SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Type of Plan	A preferred provider organization (PPO) dental plan offering in- and out-of-network benefits	
Annual Deductible	$50/person; $150/family	
Annual Maximum Benefit	$1,750/person	
PREVENTIVE CARE		
Cleaning (Two in 12 months)	100% (Deductible Waived)	
Exams	100% (Deductible Waived)	
Full Mouth X-Rays (One every 36 months)	100% (Deductible Waived)	
BASIC SERVICES		
Extractions	90%	85% of R&C*
Fillings	90%	85% of R&C*
General Anesthesia	90%	85% of R&C*
Periodontics (Gum Surgery)	60%	50% of R&C*
Root Canals	90%	85% of R&C*
MAJOR SERVICES		
Bridges (Once every 5 years)	60%	50% of R&C*
Crowns (Once every 5 years)	60%	50% of R&C*
Dentures (Once every 5 years)	60%	50% of R&C*
Orthodontia (Adults and Children)	50% up to $1,750 (per person) lifetime max.	
TMJ	Not covered	

Dental is not a stand-alone choice. This is not an official summary plan description (SPD) or official plan document. If there is a difference between what you read in this comparison chart and what you read in an official plan document, the official plan document will rule.

*Reasonable and Customary (R&C)