2024 ANTHEM HMO MEDICAL PLAN

Choice of Providers	Anthem Advantage HMO providers only. Primary care doctor or medical group selection required for each family member (may be a pediatrician for a child). All benefits must be provided or authorized by the primary care doctor or medical group. Referrals required for most specialists (except OBGYN and non-routine services/procedures.
Website (medical and prescription drugs)	www.anthem.com/ca/caltech
Phone (medical)	(866) 820-0765 For claims questions, call the customer service number on your ID card.
Phone (prescription drugs)	Anthem Pharmacy Services: (833) 261-2467 IngenioRx Home Delivery Pharmacy: (833) 236-6196
ID Card	When you first enroll, you'll receive an ID card — one card for both medical and prescription drugs — for each member of your family. Contact Anthem for replacement cards.
Plan Features	**Anthem HMO Providers Only**
Health Savings Account (HSA)	Not available
Annual Deductible (per calendar year)	No deductible
Coinsurance/Copayment (Copay)	$25 or $45 copay per doctor visit, depending on your primary care doctor/medical group selection
Out-of-Pocket/Copay Maximum (Per calendar year) Plan pays 100% of eligible expenses for covered services for the rest of the year after you reach the out-of-pocket maximum.	Includes copayments for medical and prescription drug services $1,500 per person $3,000 family maximum
How the Out-of-Pocket/Copay Maximum Works	After you pay the individual out-of-pocket maximum or the combined expenses of all covered family members reach the family maximum in any calendar year, the plan begins providing 100% coverage for services applicable to the out-of-pocket maximum.
Prior Authorization, Preservice/Concurrent Reviews	Coordinated by your Anthem primary care doctor or medical group
Coverage for Specific Services	
Acupuncture	$20 copay per visit Up to 24 visits per calendar year for acupuncture and chiropractic combined. Provided through the ASHP network. Call (800) 678-9133 for details. A referral is not required; however, if referred by your primary care doctor/medical group, you pay the applicable primary care doctor/medical group copay — $25 or $45.
Allergy Test/Treatment	100% covered
Ambulance	100% covered when emergency criteria are met or when ordered or approved by your medical group
Chiropractic Care	$20 copay per visit Up to 24 visits per calendar year for acupuncture and chiropractic combined. Provided through the ASHP network. Call (800) 678-9133 for details. A referral is not required; however, if referred by your primary care doctor/medical group, you pay the applicable primary care doctor/medical group copay — $25or $45.
Durable Medical Equipment/Hearing Aids	100% covered
Emergency Room Care	$250 copay (waived if admitted); notify your medical group; follow-up care must be authorized by your medical group
Home Health Care	$25 or $45 per visit; up to 100 visits per calendar year

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Hospice Care	100% covered
Hospitalization	$250 copay per admission, then 100% covered (semi-private room)
Infertility Diagnosis and Treatment	$10,000 calendar year maximum Outpatient and Inpatient Procedures: Plan pays 80% Imaging: Plan pays 100%
Infertility Prescription Drug Coverage	$15,000 lifetime maximum
	47% coinsurance for generic ($50 max copay) 47% coinsurance for brand ($100 max copay) 47% coinsurance for specialty/Non-preferred ($100 max copay)
LiveHealth Online Visit	$0 copay per "telehealth" Internet chat with US board-certified doctors www.livehealthonline.com
Occupational Therapy	$25 or $45 copay per visit. A referral is required. Coverage is limited to a 60-day period of care after an illness or injury, 60-day period of care is combined for Occupational, Physical and Speech therapy visits (additional visits may be covered when approved by your primary care doctor/medical group).
Physical Therapy	$25 or $45 copay per visit. A referral is required. Coverage is limited to a 60-day period of care after an illness or injury, 60-day period of care is combined for Occupational, Physical and Speech therapy visits (additional visits may be covered when approved by your primary care doctor/medical group).
Physician Office Visits	$25 or $45 per visit
Pregnancy/Maternity Care (including Routine Nursery Care)	Office visits: $25 or $45 per visit Inpatient hospital: $250 copay per admission, then 100% covered
Prescription Drug Coverage: Retail[1]	Up to a 30-day supply: $15 copay for generic $50 copay for brand-name formulary[1,2] $75 copay for brand-name non-formulary[1,2]
Prescription Drug Coverage: Mail[1]	Up to a 90-day supply: $30 copay for generic $90 copay for brand-name formulary[1,2] $150 copay for brand-name non-formulary[1,2]
Specialty Pharmacy	For up to a 30-day supply: $75 copay for specialty drugs
Preventive Care[3] • Well Baby Exams and Immunizations • Annual Exams/Physicals (one per calendar year for adults and children age 3 and over) • Preventive Care Tests and Screenings[3]	100% covered

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Psychiatric Care: Inpatient	$250 copay per admission, then 100% covered (provided through Behavioral Health Network; contact Anthem for details)
Psychiatric Care: Outpatient Day Treatment (or Outpatient Facility/Day Treatment)	100% covered
Psychiatric Care: Physician Office Visits	$25 or $45 copay per visit
Skilled Nursing Facility Care	100% covered; up to 100 days per calendar year
Speech Therapy	$25 or $45 copay per visit. A referral is required. Coverage is limited to a 60- day period of care after an illness or injury, 60-day period of care is combined for Occupational, Physical and Speech therapy visits (additional visits may be covered when approved by your primary care doctor/medical group).
Substance Abuse: Inpatient	$250 copay per admission, then 100% covered (provided through Behavioral Health Network; contact Anthem for details)
Substance Abuse: Outpatient Day Treatment (or Outpatient Facility/Day Treatment)	100% covered
Substance Abuse: Physician Office Visits	$25 or $45 copay per visit
Surgery, Outpatient (see *Hospitalization* for inpatient surgery)	$150 copay, then 100% covered
Urgent Care Office Visit	$25 or $45 copay per visit
Vision Exams and Materials	Not covered in this plan. Vision benefits are available through the Vision Service Plan (VSP) option.
X-ray and Lab	100% covered

[1]Anthem: Preauthorization is required for some drugs. For details, check with your pharmacy, call Anthem Pharmacy Services at (833) 261-2467, or visit www.anthem.com/ca/caltech (select Pharmacy, then Prior Authorization Listing). Certain non-preferred drugs are not covered unless your physician indicates Dispense as Written (DAW) or Do Not Substitute (DNS) on the prescription. For details, visit www.anthem.com/ca/caltech (select Pharmacy, then Preferred Drug Program).

[2]If you request a brand-name drug when a generic version is available, you'll pay the generic drug copay plus the difference between the price of the generic drug and the price of the brand-name drug. The price is defined as Anthem's allowed amount. If your doctor indicates Dispense as Written (DAW) on your prescription, you pay only the brand copay.

[3]Preventive care coverage includes preventive services rated A or B by the U.S. Preventive Services Task Force, based on federal regulations and age and frequency guidelines. Coverage also includes certain over-the-counter prescription drugs when prescribed by your doctor and obtained at a pharmacy counter.

SB 245 – Health Care Coverage: Abortion Services: Cost Sharing
This law requires a health plan contract issued, amended, renewed, or delivered on or after January 1, 2024, to provide coverage for abortion and abortion related services, including pre-abortion and follow-up services without imposing a deductible, coinsurance, copayment, or any other cost-sharing requirement. For a HDHP (high deductible health plan), the cost-sharing limits only apply once an enrollee's deductible has been satisfied.

For Additional Information
For additional information, including plan limits and exclusions, see the plan's benefits booklet — also called an evidence of coverage (EOC) — at www.anthem.com/ca/caltech

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This summary of plan benefits is not a contract. It describes benefits in general terms. Consult the individual plan booklets for specific details of benefit coverage. To permit a brief summary of benefits and services, use of actual contract language has been minimized. This summary does not replace the legal documents that establish the plans. Final interpretation of any provision of the plans will be governed by the master policies and service agreements, which are on file in the office of the plan administrator. The Institute expects and intends to continue the Caltech benefits program but reserves the right to amend, modify, suspend, or terminate it, in whole or in part, at any time and for any reason. If you are enrolled in Medicare, your Caltech medical plan coordinates with your Medicare Part A and B coverage.