



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, <https://eoc.anthem.com/eocdps/ca/aso>. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call (844) 647-3687 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
<b>Are there services covered before you meet your <u>deductible</u>?</b>	No.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	\$6,250/single or \$12,500/family for In-Network Providers.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Services deemed not medically necessary by Medical Management and/or Anthem, <u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. Blue Card PPO. See <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> or call (844) 647-3687 for a list of <u>network providers</u> . Benefits and costs may vary by site of service and how the <u>provider</u> bills.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>Out-of-Network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>Out-of-Network Provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .
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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25/visit	Not covered	Virtual visits (Telehealth) benefits available.
	<u>Specialist</u> visit	\$45/visit	Not covered	Virtual visits (Telehealth) benefits available.
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Pre-certification may be required.
If you need drugs to treat your illness or condition  More information about <u>prescription drug coverage</u> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a>	Typically Generic (Tier 1)	\$10/prescription (retail) and \$25/prescription (home delivery)	Not covered	Beginning with the 4th fill of a maintenance medication purchased at an in-network retail pharmacy, you will pay 50% with a maximum out-of-pocket per prescription of \$150, which will provide no credit towards the annual out-of-pocket limit. You can avoid this penalty by switching your maintenance prescriptions to mail order. Some preventive prescriptions are covered at 0% coinsurance. Beginning with the 3rd fill of a specialty maintenance medication purchased at an in-network retail pharmacy, you will pay 100% which will provide no credit towards the annual out-of-pocket limit. Amgen drugs are covered at 100%.
	Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 2)	\$30/prescription (retail) and \$75/prescription (home delivery)	Not covered	
	Typically Non-Preferred Brand and Generic drugs (Tier 3)	\$50/prescription (retail) and \$125/prescription (home delivery)	Not covered	
	Typically Preferred <u>Specialty</u> (brand and generic) (Tier 4)	\$10 copay (retail generic) \$25 copay (mail generic)  \$50 copay (retail brand) \$125 copay (mail brand)	<u>Not covered</u>	

\* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/ca/aso>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$50/visit	Not covered	Pre-certification may be required.
	Physician/surgeon fees	No charge	Not covered	-----none-----
If you need immediate medical attention	<u>Emergency room care</u>	\$150/visit	Covered as In-Network	<u>Copayment</u> waived if admitted. No charge for Emergency Room Physician Fee. Pre-certification may be required.
	<u>Emergency medical transportation</u>	No charge	Covered as In-Network	Pre-certification may be required.
	<u>Urgent care</u>	\$25/visit	Not covered	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500/admission	Not covered	Pre-certification may be required.
	Physician/surgeon fees	No charge	Not covered	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit \$25/visit Other Outpatient No charge	Office Visit Not covered Other Outpatient Not covered	Virtual visits (Telehealth) benefits available.
	Inpatient services	\$500/admission	Not covered	No charge for Inpatient Physician Fee, In-Network Providers. No Coverage for Inpatient Physician Fee Out-of-Network. Pre-certification may be required.
If you are pregnant	Office visits	\$40/visit for the first 1 visit	Not covered	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Pre-certification may be required.
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	\$500/admission	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	Not covered	100 visits/benefit period for Home Health and Private Duty Nursing combined for In-Network Providers. Pre-certification may be required.
	<u>Rehabilitation services</u>	\$30/visit	Not covered	Coverage is limited to 60 visits maximum per benefit period for each physical therapy,
	<u>Habilitation services</u>	\$30/visit	Not covered	

\* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/ca/aso>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				Occupational Therapy and Speech Therapy.
	<u>Skilled nursing care</u>	\$500/admission	Not covered	100 days/benefit period for skilled nursing services In-Network Providers. Pre-certification may be required.
	<u>Durable medical equipment</u>	50% coinsurance	Not covered	Pre-certification may be required.
If your child needs dental or eye care	<u>Hospice services</u>	No charge	Not covered	You are eligible for Hospice care if your physician and hospice medical director certify that are terminally ill and likely have 12 months or less to live for In-Network Providers.
	Children's eye exam	No charge	Not covered	Coverage limited to 1 routine eye exam per year for In-Network Providers.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	-----none-----

### Excluded Services & Other Covered Services:

#### Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic Surgery
- Glasses for a Child
- Routine foot care unless you have been diagnosed with diabetes
- Dental Care (adult)
- Long-term care
- Weight loss programs
- Dental Check-up
- Non-emergency care when traveling outside the U.S.

#### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture coverage is limited to Pain Management
- Infertility treatment
- Chiropractic care
- Private-duty nursing 100 visits/benefit period combined with Home Health
- Hearing aids 1/ear every 24 months
- Most coverage provided outside the United States. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Managed Health Care, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, (888) 466-2219, <https://www.dmhc.ca.gov/>, Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or

\* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/ca/aso>.

contact Anthem at the number on the back of your ID card. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

ATTN: Grievances and Appeals, P.O. Box 54159, Los Angeles, CA 90054-0519

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

Additionally, a consumer assistance program can help you file your appeal. Contact California Consumer Assistance Program, Operated by the California Department of Managed Health Care, 980 9th Street, Suite 500, Sacramento, CA 95814, (888) 466-2219, <https://www.dmhca.ca.gov/>

**Does this plan provide Minimum Essential Coverage? Yes.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet the Minimum Value Standards? Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

<b>The plan's overall deductible</b>	\$0
<b>Specialist copayment</b>	\$45
<b>Hospital (facility) copayment</b>	\$500
<b>Other coinsurance</b>	0%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
Diagnostic tests (*ultrasounds and blood work*)  
Specialist visit (*anesthesia*)

**Total Example Cost** **\$12,700**

In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,000
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,060</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

<b>The plan's overall deductible</b>	\$0
<b>Specialist copayment</b>	\$45
<b>Hospital (facility) copayment</b>	\$500
<b>Other coinsurance</b>	0%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Durable medical equipment (*glucose meter*)

**Total Example Cost** **\$5,600**

In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,300
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,320</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

<b>The plan's overall deductible</b>	\$0
<b>Specialist copayment</b>	\$45
<b>Hospital (facility) copayment</b>	\$500
<b>Other coinsurance</b>	0%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

**Total Example Cost** **\$2,800**

In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$700
<u>Coinsurance</u>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$800</b>

The plan would be responsible for the other costs of these EXAMPLE covered services.

# Get help in your language

## Language Assistance Services

Curious to know what all this says? We would be too. Here's the English version: **IMPORTANT:** Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD:711)

Separate from our language assistance program, we make documents available in alternative formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

### Spanish

**IMPORTANTE:** ¿Puede leer esta carta? Si no, podemos pedirle a alguien que le ayude a leerla. También es posible que pueda solicitar que le envíemos esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721 (TTY/TDD: 711).

### Arabic

هام: هل تستطيع قراءة هذه الرسالة؟ إذا لم يكن الأمر كذلك، يمكننا أن نطلب من شخص ما مساعدتك في قرائتها. قد نتمكن أيضًا من الحصول على هذه الرسالة مكتوبة بلغتك للحصول على مساعدة مجانية، يرجى الاتصال على الفور على الرقم 1-888-254-2721. (TTY/TDD: 711)

### Armenian

ՈՒՆԵՐԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք կարդալ այս նամակը: Եթե ոչ, մենք կարող ենք առաջարկել որևէ մեկի օգնությունը՝ ձեզ համար այն կարդալու համար: Դուք կարող եք նաև այս նամակը ստանալ ձեր լեզվով: Անվճար օգնության համար խնդրում ենք անմիջապես զանգահարել՝ 1-888-254-2721. (TTY/TDD: 711)

### Chinese

重要：您能看此信嗎？如果不能，我們可以請人幫您看。您還可以獲得以您的語言寫的此信件。如需免費幫助，請立即致電 1-888-254-2721. (TTY/TDD:711)

### Farsi

بخواهیم شخصی از توانیمی ما، توانیدنی اگر بخواهید؟ را نامه این توانید می آیا: مهم کتبی صورت به را نامه این بتوانید است ممکن همچنین. کند کمک شما به آن خواندن در شماره با فوراً لطفاً، رایگان کمک دریافت برای. کنید دریافت خودتان زبان به و بگیرید تماس (TTY/TDD: 711). 1-888-254-2721. (TTY/TDD: 711)

### Hindi

महत्वपूर्णः क्या आप यह पत्र पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में किसी की मदद ले सकते हैं। यह पत्र आप अपनी भाषा में भी लिखवा सकते हैं। नि:शुल्क सहायता के लिए, कृपया तुरंत 1-888-254-2721 पर कॉल करें। (टीटीवाई/टीडीडी:711)

### Hmong

TSEEM CEEB: Koj puas nyeem tau daim ntawv no? Yog tias tsis tau, peb muaj qee tus neeg pab nyeem nws rau koj. Koj los kuj yuav tau txais ib daim ntawv sau ua kom yam lus. Rau kev pab dawb, thov hu tam sim ntawm 1-888-254-2721. (TTY/TDD: 711)

### Japanese

重要：この文書を読むことができますか？読むことができない場合、支援することができます。また、日本語で訳されたこの文書を書面で受け取ることができます。無料の支援をご希望の場合、1-888-254-2721 (TTY/TDD:711) にご連絡ください。

## Khmner

សំខាន់៖ តើអ្នកអាចអាណសំបុត្រនេះចាប់ទេ? បើអត់ទេ  
យើងអាចអាណអ្នកដឹងអាណ។  
អ្នកត្រូវអាចទទួលបានសំបុត្រនេះសរស់ជាការបស់អ្នកដឹងដែរ។  
ស្រាប់ជំនួយដោយ តាមគិតផ្សេងៗ  
ស្ថិកទូរសព្ទមកពាណិជ្ជកម្ម: លេខ 1-888-254-2721.  
(TTY/TDD: 711)

## Korean

중요: 이 편지를 읽으실 수 있으신가요? 그렇지 않으신 경우,  
이를 읽으실 수 있도록 도움을 제공해 드릴 수 있습니다.  
귀하의 모국어로 된 편지를 우편으로 받아보실 수도 있습니다.  
무상으로 제공되는 도움이 필요하신 경우,  
1-888-254-2721번으로 바로 연락해 주십시오.  
(TTY/TDD: 711)

## Punjabi

ਕੀ ਤੁਸੀਂ ਇਹ ਚਿੱਠੀ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ  
ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਸ ਚਿੱਠੀ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵੀ ਲਿਖ  
ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਤੁਰੰਤ ਇਸ 'ਤੇ ਕਾਲ ਕਰੋ  
1-888-254-2721। (TTY/TDD: 711)

## Russian

ВАЖНАЯ ИНФОРМАЦИЯ: Можете ли вы прочитать данное  
письмо? Если нет, наш специалист поможет вам в этом. Вы  
также можете получить данное письмо на вашем языке. Для  
получения бесплатной помощи звоните по номеру  
1-888-254-2721. (TTY/TDD: 711)

## Tagalog

MAHALAGA: Mababasa mo ba ang sulat na ito? Kung hindi,  
mayroon kaming makakatulong sa iyo na basahin ito. Maaari  
mo ring makuha ang sulat na ito nang nakasulat sa iyong  
wika. Para sa libreng tulong, mangyaring tumawag kaagad  
sa 1-888-254-2721. (TTY/TDD: 711)

## Thai

ສໍາຄັງ: ດັ່ງກ່າວສາມາດຮັບອະນຸຍານນີ້ໄດ້ຫຼືວ່າໄມ້ ແກ່າວດັ່ງກ່າວອະນຸຍານນີ້ໄມ້ໄດ້  
ເຮົາສາມາດຮັບອ່ານໄຫ້ ໄກສັກຄນ່າຍ້ອງດັ່ງກ່າວໄດ້ ດັ່ງກ່າວສາມາດຮັບອ່ານໄຫ້  
ຈົດໝາຍນີ້ທີ່ເຂີຍໃນພາສາຂອງດັ່ງກ່າວໄດ້ເຊັ່ນກັນ  
ໜາກຕ້ອງການຄວາມໝ່າຍແລລືອແບບໄນ້ມີຄ່າໃຊ້ຈ່າຍ ໂປຣໂທຮ່າວເຮົາໄດ້ທັນທີ່  
1-888-254-2721. (TTY/TDD: 711)

## Vietnamese

QUAN TRỌNG: Quý vị có đọc được lá thư này không? Nếu  
không, chúng tôi có thể nhờ ai đó giúp quý vị đọc. Quý vị  
cũng có thể yêu cầu thư này viết bằng ngôn ngữ của quý vị.  
Để được trợ giúp miễn phí, hãy gọi ngay đến số  
1-888-254-2721. (TTY/TDD: 711)

## **It's important we treat you fairly**

We follow state and federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services, in a timely manner, like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or if you think you were discriminated against based on race, color, national origin, age, disability, or sex, you can mail a complaint directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>