
 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 (800) 756-7274 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$3,000/individual or \$6,000/family for In- <a href="#">Network Providers</a> . \$6,000/individual or \$12,000/family for Out-of- <a href="#">Network Providers</a> .	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the policy, the overall family <a href="#">deductible</a> is not required to be met before the <a href="#">plan</a> begins to pay.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> for In- <a href="#">Network Providers</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain preventive services without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$5,000/individual or \$10,000/family for In- <a href="#">Network Providers</a> . \$10,000/individual or \$20,000/family for Out-of- <a href="#">Network Providers</a> .	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , the overall family <a href="#">out-of-pocket limit</a> is not required to be met before an individual meets their out-of-pocket.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Services deemed not medically necessary by Medical Management and/or Anthem, <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes, Blue Card PPO. See <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> or call (800) 756-7274 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an out-of- <a href="#">network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an out-of- <a href="#">network provider</a>

		for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Specialist</a> visit	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Vision care (non-routine exam): 20% a visit for Network providers.
	<a href="#">Preventive care</a> / <a href="#">screening</a> /immunization	No charge	50% <a href="#">coinsurance</a>	Pap smear (routine) and Mammography (routine): 50% <a href="#">coinsurance deductible</a> does not apply for In- <a href="#">Network Providers</a> . Vision screening. No charge. You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
	Imaging (CT/PET scans, MRIs)	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.expressscripts.com">www.expressscripts.com</a>	Tier 1 - Generic	\$10 copay/retail pharmacy \$20 copay/mail order or Smart90 (CVS and Walgreens)	Not covered	Member must meet the integrated medical/Rx deductible before copayment/coinsurance is applicable except for drugs that are classified by the health care reform law as preventive which is covered at 100%. Retail supply: 30-day limit Mail Order supply: 90-day limit. Formulary exclusions apply
	Tier 2 - <a href="#">Preferred</a> / Brand	30% (\$30 min/\$60 max)/retail pharmacy 30% (\$60 min/\$120 max)/mail order or Smart90(CVS and Walgreens)	Not covered	
	Tier 3 - Non- <a href="#">Preferred</a> Brand	50% (\$60 min/\$120 max)/retail pharmacy 50% (\$120 min/\$240 max)/mail order or	Not covered	After a maintenance prescription is filled 2 times at retail, day supply (d/s) is limited to 90 d/s, 100% co-pay/co-insurance applies for retail claims, and

\* For more information about limitations and exceptions, see [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)	
		Smart90(CVS and Walgreens)		this amount does not accumulate toward the out-of-pocket maximum
	Tier 4 - <a href="#">Specialty</a> Self-Injectable (brand and generic)	20% (\$100 max)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
If you need immediate medical attention	<a href="#">Emergency room care</a>	30% <a href="#">coinsurance</a>	Covered as In- <a href="#">Network</a>	20% <a href="#">coinsurance</a> for Emergency Room Physician Fee.
	<a href="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a>	Covered as In- <a href="#">Network</a>	-----none-----
	<a href="#">Urgent care</a>	30% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit 30% <a href="#">coinsurance</a> Other Outpatient 30% <a href="#">coinsurance</a>	Office Visit 50% <a href="#">coinsurance</a> Other Outpatient 50% <a href="#">coinsurance</a>	Office Visit -----none----- Other Outpatient -----none-----
	Inpatient services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> for Inpatient Physician Fee In- <a href="#">Network Providers</a> . 50% <a href="#">coinsurance</a> for Inpatient Physician Fee Out-of- <a href="#">Network Providers</a> .
If you are pregnant	Office visits	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	180 visits/benefit period including private duty nursing.
	<a href="#">Rehabilitation services</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	*See Therapy Services section
	<a href="#">Habilitation services</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	180 visits/benefit period.
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----

\* For more information about limitations and exceptions, see [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)	
	<a href="#">Hospice services</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	*See Vision Services section
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	*See Dental Services section

**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](#).)**

- |  |  |  |
|--|--|--|
| <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Eye exams for a child</li> <li>• Long- term care</li> </ul> | <ul style="list-style-type: none"> <li>• Dental care (adult)</li> <li>• Glasses for a child</li> <li>• Private-duty nursing</li> </ul> | <ul style="list-style-type: none"> <li>• Dental Check-up</li> <li>• Infertility treatment</li> <li>• Routine eye care/exam (adult)</li> <li>• Emergency coverage provided outside the United States. See <a href="http://www.bcbsglobalcore.com">www.bcbsglobalcore.com</a></li> </ul> |
| <ul style="list-style-type: none"> <li>• Routine foot care unless you have been diagnosed with diabetes.</li> </ul>              | <ul style="list-style-type: none"> <li>• Weight loss programs</li> </ul>   |  |

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

- |   |  |   |
|---|--|---|
| <ul style="list-style-type: none"> <li>• Abortion</li> <li>• Acupuncture</li> <li>• Hearing aids</li> </ul> | <ul style="list-style-type: none"> <li>• Bariatric surgery (Only for Morbid Obesity).</li> <li>• Most coverage provided outside the United States. See <a href="http://www.bcbsglobalcore.com">www.bcbsglobalcore.com</a></li> </ul> | <ul style="list-style-type: none"> <li>• Chiropractic care</li> </ul> |
|---|--|---|

**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 Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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 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](#), PO Box 54159, Los Angeles, CA 90054-0159

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

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

**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.*—————

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

## 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)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000
■ <a href="#">Specialist coinsurance</a>	30%
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

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
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In this example, Peg would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$3,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,800
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,860</b>

### Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000
■ <a href="#">Specialist coinsurance</a>	30%
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

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
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In this example, Joe would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$3,000
<a href="#">Copayments</a>	\$100
<a href="#">Coinsurance</a>	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$3,920</b>

### Mia's Simple Fracture (in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000
■ <a href="#">Specialist coinsurance</a>	30%
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

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
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In this example, Mia would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$3,000
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$3,310</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



## Language Access Services:

(TTY/TDD: 711)

**Albanian (Shqip):** Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (800) 756-7274

**Amharic (አማርኛ):-** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (800) 756-7274 ይደውሉ።

**Arabic (العربية):** إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (800) 756-7274.

**Armenian (հայերեն).** Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (800) 756-7274:

**Bassa (Bàsɔ̀ wùdù):** M̄ dyi dyi-diè-dɛ̀ b̄é b̄édé b̄á céè-dɛ̀ nià ke dyí ní, ɔ̀ m̄ò ni dyí-b̄édè̀n-dɛ̀ b̄é m̄ ké gbo-kpá-kpá kè b̄ɔ̀ kpɔ̀ dɛ̀ m̄ bídí-wùdù̀n b̄ó pídyi. B̄é m̄ ké wuɖu-zìin-nyò d̄ò gbo wùdù̀ ke, d̄á (800) 756-7274.

**Bengali (বাংলা):** যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (800) 756-7274 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (800) 756-7274 သို့ ခေါ်ဆိုပါ။

**Chinese (中文):** 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (800) 756-7274。

**Dinka (Dinka):** Na nɔŋ thiëc nē ke de yā thorē, ke yin nɔŋ loŋ bē yi kuony ku wēr alēu bē gɛɛr yic yin ne thoŋ du ke cin wēu tāāuē ke piny. Te kōr yin ba jam wēnē ran ye thok geryic, ke yin cōl (800) 756-7274.

**Dutch (Nederlands):** Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (800) 756-7274.

**Farsi (فارسی):** در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (800) 756-7274 تماس بگیرید.

**French (Français):** Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (800) 756-7274.

## Language Access Services:

**German (Deutsch):** Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (800) 756-7274.

**Greek (Ελληνικά):** Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (800) 756-7274.

**Gujarati (ગુજરાતી):** જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (800) 756-7274.

**Haitian Creole (Kreyòl Ayisyen):** Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (800) 756-7274.

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