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/1ZQESMG01012017. 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/ or call (855) 383-7248 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,250**/person or **$2,500**/family for In-Network Providers. **$2,500**/person or **$5,000**/family for Out-of-Network Providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive Care, Dental, Tier 1a and Tier 1b Prescription Drugs and Vision for In-Network Providers. Dental and Vision for Out-of-Network Providers.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. **$250**/person or **$500**/family for In-Network Providers for Tier 2, Tier 3 and Tier 4 Prescription Drugs. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$7,150**/person or **$14,300**/family for In-Network Providers. **$14,300**/person or **$28,600**/family for Out-of-Network Providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, Balance-Billing charges, and Health Care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network	Yes, Advantage PPO. See www.anthem.com/ca or call	You pay the least if you use a provider in Preferred Network. You pay more if you use a

provider?	(855) 383-7248 for a list of network providers.	provider in In-Network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Non-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	Not Applicable	$25/visit for first 3 non-preventive visits deductible does not apply and 40% coinsurance	50% coinsurance	All office visit copayments count towards the same 3 visit limit.
	Specialist visit	Not Applicable	$25/visit for first 3 non-preventive visits deductible does not apply and 40% coinsurance	50% coinsurance	All office visit copayments count towards the same 3 visit limit.
	Preventive care/screening/ immunization	Not Applicable	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office Not Applicable X-Ray – Office Not Applicable	Lab – Office 40% coinsurance X-Ray – Office 40% coinsurance	Lab – Office 50% coinsurance X-Ray – Office 50% coinsurance	Lab – Office --------none-------- X-Ray – Office --------none--------
	Imaging (CT/PET scans, MRIs)	40% coinsurance	40% coinsurance	50% coinsurance	$380 maximum benefit/admission for Non-Network Providers.
If you need drugs to treat your illness or condition	Tier 1a - Typically Lower Cost Generic	Not Applicable	$5/prescription (retail) and $13/prescription (home delivery)	Not covered	*See Prescription Drug section

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/ca/1ZQESMG01012017.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
More information about **prescription drug coverage** is available at http://www.anthem.com/pharmacyinformation/			deductible does not apply		
	Tier 1b - Typically Generic	Not Applicable	$20/prescription (retail) and $50/prescription (home delivery) deductible does not apply	Not covered	
	Tier 2 - Typically Preferred Brand & Non-Preferred Generics	Not Applicable	$40/prescription (retail) and $120/prescription (home delivery) , Prescription Drug deductible applies	Not covered	
	Tier 3 - Typically Non-Preferred Brand	Not Applicable	$80/prescription (retail) and $240/prescription (home delivery) , Prescription Drug deductible applies	Not covered	
	Tier 4 - Typically Specialty (brand and generic)	Not Applicable	30% coinsurance up to a $250 maximum (retail and home delivery) , Prescription Drug deductible applies	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	$250/admission then 40% coinsurance	50% coinsurance	$380 maximum benefit/admission for Non-Network Providers.
	Physician/surgeon fees	Not Applicable	40% coinsurance	50% coinsurance	--------none--------
If you need immediate medical attention	Emergency room care	Not Applicable	$300/visit then 40% coinsurance	Covered as In-Network	Copay waived if admitted.
	Emergency medical transportation	Not Applicable	40% coinsurance	Covered as In-Network	--------none--------
	Urgent care	Not Applicable	40% coinsurance	50% coinsurance	--------none--------

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/ca/1ZQESMG01012017.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	$500/admission then 40% coinsurance	50% coinsurance	$650 maximum benefit/day for Non-Network Providers. 100 days/benefit period Inpatient rehabilitation and skilled nursing services combined.
	Physician/surgeon fees	Not Applicable	40% coinsurance	50% coinsurance	--------none--------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit Not Applicable Other Outpatient Not Applicable	Office Visit $25/visit for first 3 non-preventive visits deductible does not apply and 40% coinsurance Other Outpatient 40% coinsurance	Office Visit 50% coinsurance Other Outpatient 50% coinsurance	Office Visit All office visit copayments count towards the same 3 visit limit. Other Outpatient --------none--------
	Inpatient services	40% coinsurance	$500/admission then 40% coinsurance	50% coinsurance	$650 maximum benefit/day for Non-Network Providers.
If you are pregnant	Office visits	Not Applicable	$25/visit for first 3 non-preventive visits deductible does not apply and 40% coinsurance	50% coinsurance	Cost sharing does not apply for preventive services. In-Network preventative prenatal services are covered at 100% $650 maximum benefit/day for Non-Network Providers. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Not Applicable	40% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	40% coinsurance	$500/admission then 40% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	Not Applicable	40% coinsurance	50% coinsurance	$75 maximum benefit/visit for Non-Network Providers. 100 visits/benefit period Private duty nursing and home health combined.
	Rehabilitation services	Not Applicable	40% coinsurance	50% coinsurance	*See Therapy Services section
	Habilitation services	Not Applicable	40% coinsurance	50% coinsurance	
	Skilled nursing care	40% coinsurance	40% coinsurance	50% coinsurance	$150 maximum benefit/day for

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/ca/1ZQESMG01012017.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
			then $500/admission		Non-Network Providers. 100 days/benefit period Inpatient rehabilitation and skilled nursing services combined.
	Durable medical equipment	Not Applicable	50% coinsurance	50% coinsurance	--------none--------
	Hospice services	Not Applicable	0% coinsurance	50% coinsurance	--------none--------
If your child needs dental or eye care	Children's eye exam	Not Applicable	No charge	No charge	*See Vision Services section
	Children's glasses	Not Applicable	No charge	No charge	
	Children's dental check-up	Not Applicable	No charge	No charge	*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.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Routine foot care
- Weight loss programs

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

- Abortion
- Acupuncture
- Bariatric surgery
- Spinal manipulation 20 visits/benefit period.
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Private-duty nursing 100 visits/benefit period combined with home health.
- Routine eye care (Adult) 1 exam/benefit period.

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's Employee Benefits Security Administration at (866) 444-EBSA (3272) or 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 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:

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/ca/1ZQESMG01012017.

ATTN: Grievances and Appeals, P.O. Box 4310, Woodland Hills, CA 91365-4310

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

Department of Managed Health Care, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, (888) HMO-2219

California Consumer Assistance Program, Operated by the California Department of Managed Health Care, 980 9th St, Suite #500, Sacramento, CA 95814, (888) 466-2219, http://www.HealthHelp.ca.gov

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

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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/1ZQESMG01012017.

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 plan's overall deductible	$1,250
Specialist *coinsurance*	40%
Hospital (facility) *coinsurance*	40%
Other *coinsurance*	40%

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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,250
Copayments	$20
Coinsurance	$5,039
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,369**

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

The plan's overall deductible	$1,250
Specialist *coinsurance*	40%
Hospital (facility) *coinsurance*	40%
Other *coinsurance*	40%

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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$969
Copayments	$2,035
Coinsurance	$479
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$3,538**

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

The plan's overall deductible	$1,250
Specialist *coinsurance*	40%
Hospital (facility) *coinsurance*	40%
Other *coinsurance*	40%

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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,151
Copayments	$0
Coinsurance	$774
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,925**

The plan would be responsible for the other costs of these EXAMPLE covered 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 (855) 383-7248

Amharic (አማርኛ)፦ ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 383-7248 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 (855) 383-7248.

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՝ (855) 383-7248:

Bassa (Bǎsɔ́ɔ̀ Wùdù): Mˋ dyi dyi-diè-dɛ̀ bě bédé bá céè-dɛ̀ nià kɛ dyí ní, ɔ mɔ̀ nì dyí-bɛ̀dɛ̀ìn-dɛ̀ bɛ́ m̀ ké gbo-kpá-kpá kè bɔ̌ kpɔ̃ dé m̀ bídí-wùdùǔn bó pídyi. Bé m̀ ké wudu-zììn-nyɔ̀ dò gbo wùdù kɛ, dá (855) 383-7248.

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 (855) 383-7248 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အခမဲ့အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် (855) 383-7248 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 (855) 383-7248。

Dinka (Dinka): Na nɔŋ thiëëc në ke de yä thorë, ke yin nɔŋ loŋ bë yi kuony ku wɛr alëu bë gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kɔr yin ba jam wënë ran ye thok geryic, ke yin cɔl (855) 383-7248.

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 (855) 383-7248.

Farsi (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (855) 383-7248 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 (855) 383-7248.

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 (855) 383-7248.

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 (855) 383-7248.

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 (855) 383-7248.

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 (855) 383-7248.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (855) 383-7248 ।

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (855) 383-7248.

Igbo (Igbo): Ọ bụr ụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (855) 383-7248.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (855) 383-7248.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (855) 383-7248.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (855) 383-7248

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(855) 383-7248 にお電話ください。

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ (855) 383-7248 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (855) 383-7248.

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