




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/5SVGSMG01012021>. 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 (855) 383-7248 to request a copy.

| Important Questions   | Answers  | Why This Matters:  |
|---|--|--|
| What is the overall <a href="#">deductible</a> ?                                | \$0.   | See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.  |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. Primary Care <a href="#">Specialist</a> Visit <a href="#">Preventive Care</a> for In- <a href="#">Network Providers</a> . Tier 1 Tier 2 Tier 3 Tier 4 <a href="#">Prescription Drugs</a> for <a href="#">Preferred Network</a> and In- <a href="#">Network Providers</a> . Vision 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 <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> 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> ? | \$6,000/person or \$12,000/family for In- <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> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.  |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <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, California Care HMO. See <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> or call (855) 383-7248 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 <a href="#">Out-of-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 <a href="#">Out-of-Network Provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |

|  |      |  |
|--|------|--|
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ? | Yes. | This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</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  |
|---|--|--|---|--|---|
|   |  | 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 <a href="#">provider's</a> office or clinic  | Primary care visit to treat an injury or illness                           | Not Applicable   | \$30/visit  | Not covered  | -----none-----  |
|   | <a href="#">Specialist</a> visit   | Not Applicable   | \$55/visit  | Not covered  | -----none-----  |
|   | <a href="#">Preventive care</a> / <a href="#">screening</a> / immunization | Not Applicable   | No charge   | Not covered  | 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)                        | Lab – Office<br>Not Applicable<br>X-Ray – Office<br>Not Applicable                     | Lab – Office<br>\$15/visit<br>X-Ray – Office<br>\$15/service              | Lab – Office<br>Not covered<br>X-Ray – Office<br>Not covered | -----none-----  |
|   | Imaging (CT/PET scans, MRIs)   | Not Applicable   | \$250/procedure   | Not covered  | -----none-----  |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a><br><br>Select Drug List | Tier 1 - Typically Generic   | \$15/prescription (retail) and<br>\$38/prescription (home delivery)                    | \$25/prescription (retail only)   | Not covered (retail and home delivery)                       | Most home delivery is 90-day supply. *See Prescription Drug section of the <a href="#">plan</a> or policy document (e.g. evidence of coverage or certificate).                            |
|   | Tier 2 - Typically Preferred Brand & Non-Preferred Generic Drugs           | \$40/prescription (retail) and<br>\$120/prescription (home delivery)                   | \$60/prescription (retail only)   | Not covered (retail and home delivery)                       |   |
|   | Tier 3 - Typically Non-Preferred Brand and Generic drugs                   | \$80/prescription (retail) and<br>\$240/prescription (home delivery)                   | \$90/prescription (retail only)   | Not covered (retail and home delivery)                       |   |
|   | Tier 4 - Typically Preferred Specialty (brand and generic)                 | 30% <a href="#">coinsurance</a> up to<br>\$250/prescription (retail and home delivery) | 40% <a href="#">coinsurance</a> up to<br>\$250/prescription (retail only) | Not covered (retail and home delivery)                       |   |

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/ca/5SVGSMG01012021>.

| 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 outpatient surgery  | Facility fee (e.g., ambulatory surgery center)   | Not Applicable                                      | \$300/visit   | Not covered  | Costs may vary by site of service.   |
|   | Physician/surgeon fees                           | Not Applicable                                      | No charge   | Not covered  | -----none-----   |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | Not Applicable                                      | \$300/visit   | Covered as In-<br><a href="#">Network</a>                      | Copay waived if admitted. No charge for Emergency Room Physician Fee In- <a href="#">Network</a> and Non- <a href="#">Network Providers</a> .  |
|   | <a href="#">Emergency medical transportation</a> | Not Applicable                                      | \$150/trip  | Covered as In-<br><a href="#">Network</a>                      | Non-emergency non- <a href="#">network</a> Ambulance Services are limited to \$50,000 per occurrence.  |
|   | <a href="#">Urgent care</a>                      | Not Applicable                                      | \$30/visit  | Not covered  | -----none-----   |
| If you have a hospital stay   | Facility fee (e.g., hospital room)               | Not Applicable                                      | \$600/day up to 4 days/admission                              | Not covered  | 100 days/benefit period for Inpatient rehabilitation for In- <a href="#">Network Providers</a> .   |
|   | Physician/surgeon fees                           | Not Applicable                                      | No charge   | Not covered  | -----none-----   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | Not Applicable                                      | Office Visit<br>\$30/visit<br>Other Outpatient<br>\$300/visit | Office Visit<br>Not covered<br>Other Outpatient<br>Not covered | Office Visit<br>-----none-----<br>Other Outpatient<br>-----none-----   |
|   | Inpatient services                               | Not Applicable                                      | \$600/day up to 4 days/admission                              | Not covered  | No charge for Inpatient Physician Fee In- <a href="#">Network Providers</a> . No Coverage for Inpatient Physician Fee Non- <a href="#">Network Providers</a> .   |
| If you are pregnant   | Office visits                                    | Not Applicable                                      | No charge   | Not covered  | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . \$30/visit for Postnatal <a href="#">Preferred Network Providers</a> . In- <a href="#">Network</a> preventative prenatal and postnatal services are covered at 100%. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). *Coverage |
|   | Childbirth/delivery professional services        | Not Applicable                                      | No charge   | Not covered  |  |
|   | Childbirth/delivery facility services            | Not Applicable                                      | \$600/day up to 4 days/admission                              | Not covered  |  |

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/ca/5SVGSMG01012021>.

| 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) |   |
|  |   |   |   |  | includes fertility preservation services, see Fertility Preservation section.                                 |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | Not Applicable                                      | \$55/visit                              | Not covered                                  | 100 visits/year for Home Health and Private Duty Nursing combined for In- <a href="#">Network Providers</a> . |
|  | <a href="#">Rehabilitation services</a>   | Not Applicable                                      | \$30/visit                              | Not covered                                  | *See Therapy Services section.  |
|  | <a href="#">Habilitation services</a>     | Not Applicable                                      | \$30/visit                              | Not covered                                  |   |
|  | <a href="#">Skilled nursing care</a>      | Not Applicable                                      | \$300/day up to 4 days/admission        | Not covered                                  | 100 days/benefit period for skilled nursing services for In- <a href="#">Network Providers</a> .              |
|  | <a href="#">Durable medical equipment</a> | Not Applicable                                      | \$100/visit                             | Not covered                                  | *See <a href="#">Durable Medical Equipment</a> Section  |
|  | <a href="#">Hospice services</a>          | Not Applicable                                      | No charge                               | Not covered                                  | -----none-----  |
| If your child needs dental or eye care                         | Children's eye exam                       | Not Applicable                                      | No charge                               | Not covered                                  | *See Vision Services section  |
|  | Children's glasses                        | Not Applicable                                      | No charge                               | Not covered                                  |   |
|  | Children's dental check-up                | Not Applicable                                      | 0% <a href="#">coinsurance</a>          | 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](#).)

- Cosmetic surgery
- Infertility treatment
- Routine foot care unless medically necessary
- Dental care (Adult)
- Long-term care
- Weight loss programs
- Hearing aids
- 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
- Private-duty nursing 100 visits/year combined with Home Health
- Bariatric surgery
- Routine eye care (Adult) 1 exam/benefit period.
- Chiropractic care 20 visits/year

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/ca/5SVGSMG01012021>.

**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 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 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 4310, Woodland Hills, CA 91365-4310

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

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/>

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

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/ca/5SVGSMG01012021>.

## 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> | \$0   |
| ■ <a href="#">Specialist copayment</a>                          | \$55  |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$600 |
| ■ Other <a href="#">copayment</a>                               | \$15  |

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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <a href="#">Cost Sharing</a>      |              |
|-----------------------------------|--------------|
| <a href="#">Deductibles</a>       | \$0          |
| <a href="#">Copayments</a>        | \$900        |
| <a href="#">Coinsurance</a>       | \$0          |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$60         |
| <b>The total Peg would pay is</b> | <b>\$960</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> | \$0   |
| ■ <a href="#">Specialist copayment</a>                          | \$55  |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$600 |
| ■ Other <a href="#">copayment</a>                               | \$15  |

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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <a href="#">Cost Sharing</a>      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$0            |
| <a href="#">Copayments</a>        | \$1,600        |
| <a href="#">Coinsurance</a>       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,620</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> | \$0   |
| ■ <a href="#">Specialist copayment</a>                          | \$55  |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$600 |
| ■ Other <a href="#">copayment</a>                               | \$15  |

This EXAMPLE event includes services like:

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

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <a href="#">Cost Sharing</a>      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$0            |
| <a href="#">Copayments</a>        | \$1,100        |
| <a href="#">Coinsurance</a>       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,100</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 (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 (Bàsɔ̀ Wùdù):** M̄ dyi dyi-diè-djè bɛ́ bédjé b́á céè-djè nìà kɛ dyí ní, ɔ̀ m̀d̀ nì dyí-bɛ̀d̀jè̀n-djè bɛ́ m̀ kɛ́ gbo-kpá-kpá kè b̄́ k̄p̄ d̄é m̀ b́í d̄í-wùdù̀n b́ó p̄ídyi. B́é m̀ kɛ́ wuɖu-zìin-nyò d̀ò gbo wùdù kɛ, d̄á (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 အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (855) 383-7248 သို့ ခေါ်ဆိုပါ။

**Chinese (中文):** 如果您对本文件有任何疑问，您有权使用您的语言免费获得协助和资讯。如需与译员通话，请致电(855) 383-7248。

**Dinka (Dinka):** Na nɔŋ thiëc në ke de yā thorë, ke yin nɔŋ loŋ bē yi kuony ku wɛr alëu bē gɛɛr yic yin ne thoŋ du ke cin wëu tāäuë ke piny. Te kør yin ba jam wënë ran ye thok geryic, ke yin col (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 هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (855) 383-7248 تماس بگیرید.

## Language Access Services:

**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.

**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.

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