




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/5SYUSMG01012021>. 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 ? | \$750/person or \$2,250/family for In- Network Providers . \$2,000/person or \$4,000/family for Non- 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. Primary Care Specialist Visit Preventive Care for In- Network Providers . Vision for In- Network and Non- 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 Prescription Drugs for Preferred Network and In- Network Providers combined. 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 ? | \$7,800/person or \$15,600/family for In- Network Providers . \$15,600/person or \$31,200/family for Non- 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 doesn't 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 provider ? | Yes, Prudent Buyer PPO. See www.anthem.com/ca or call (855) 383-7248 for a list of | This plan uses a provider network . You will pay less if you use a provider in the plan's 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 |

| | | |
|--|------------------------------------|--|
| | network providers. | 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 | \$30/visit deductible does not apply | 50% coinsurance | -----none----- |
| | Specialist visit | Not Applicable | \$55/visit deductible does not apply | 50% coinsurance | -----none----- |
| | 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 \$15/visit, deductible does not apply X-Ray – Office \$15/service, deductible does not apply | Lab – Office 50% coinsurance X-Ray – Office 50% coinsurance | -----none----- |
| | Imaging (CT/PET scans, MRIs) | Not Applicable | \$100/service then 20% coinsurance | 50% coinsurance | \$380 maximum/admission for Non- Network Providers . |
| If you need drugs to treat your illness or condition More information about prescription | Tier 1 - Typically Generic | \$15/prescription, Prescription Drug deductible does not apply (retail) and \$38/prescription, Prescription Drug | \$25/prescription, Prescription Drug deductible does not apply (retail only) | Not covered (retail and home delivery) | Most home delivery is 90-day supply. *See Prescription Drug section of the plan or policy document (e.g. evidence of coverage or certificate). |

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/ca/5SYUSMG01012021>.

| 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) | |
| <p>drug coverage is available at http://www.anthem.com/pharmacyinformation/</p> <p>Select Drug List</p> | | deductible does not apply (home delivery) | | | |
| | Tier 2 - Typically Preferred Brand & Non-Preferred Generic Drugs | \$45/prescription, Prescription Drug deductible applies (retail) and \$135/prescription, Prescription Drug deductible applies (home delivery) | \$65/prescription, Prescription Drug deductible applies (retail only) | Not covered (retail and home delivery) | |
| | Tier 3 - Typically Non-Preferred Brand and Generic drugs | \$85/prescription, Prescription Drug deductible applies (retail) and \$255/prescription, Prescription Drug deductible applies (home delivery) | \$95/prescription, Prescription Drug deductible applies (retail only) | Not covered (retail and home delivery) | |
| | Tier 4 - Typically Preferred Specialty (brand and generic) | 30% coinsurance up to \$250/prescription, Prescription Drug deductible applies (retail and home delivery) | 40% coinsurance up to \$250/prescription, Prescription Drug deductible applies (retail only) | Not covered (retail and home delivery) | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | Not Applicable | 20% coinsurance | 50% coinsurance | Costs may vary by site of service.\$380 maximum/admission for Non- Network Providers . |
| | Physician/surgeon fees | Not Applicable | 20% coinsurance | 50% coinsurance | -----none----- |
| If you need immediate | Emergency room care | Not Applicable | \$250/visit then 20% coinsurance | Covered as In- Network | Copay waived if admitted. 20% coinsurance for Emergency |

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|---|--|---|---|--|--|
| | | Preferred Network Provider (You will pay the least) | In-Network Provider (You will pay more) | Non-Network Provider (You will pay the most) | |
| | | | | | Room Physician Fee In- Network and Non- Network Providers . |
| | Emergency medical transportation | Not Applicable | 20% coinsurance | Covered as In- Network | -----none----- |
| | Urgent care | Not Applicable | \$55/visit deductible does not apply | 50% coinsurance | -----none----- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | Not Applicable | 20% coinsurance | 50% coinsurance | \$650 maximum/day for Non- Network Providers . 100 days/benefit period for Inpatient rehabilitation for In- Network and Non- Network Providers combined. |
| | Physician/surgeon fees | Not Applicable | 20% coinsurance | 50% coinsurance | -----none----- |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Not Applicable | Office Visit \$30/visit deductible does not apply Other Outpatient 20% coinsurance | Office Visit 50% coinsurance Other Outpatient 50% coinsurance | Office Visit -----none----- Other Outpatient -----none----- |
| | Inpatient services | Not Applicable | 20% coinsurance | 50% coinsurance | \$650 maximum/day for Non- Network Providers . 20% coinsurance for Inpatient Physician Fee In- Network Providers . 50% coinsurance for Inpatient Physician Fee Non- Network Providers . |
| If you are pregnant | Office visits | Not Applicable | No charge | 50% coinsurance | Cost sharing does not apply for preventive services . \$30/visit deductible does not apply for Postnatal Preferred Network Providers . Not covered for Postnatal In- Network Providers . 50% coinsurance for Postnatal |
| | Childbirth/delivery professional services | Not Applicable | 20% coinsurance | 50% coinsurance | |
| | Childbirth/delivery facility services | Not Applicable | 20% coinsurance | 50% coinsurance | |

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|--|---|---|--|---|--|
| | | Preferred Network Provider (You will pay the least) | In-Network Provider (You will pay more) | Non-Network Provider (You will pay the most) | |
| | | | | | Non- Network Providers . In- Network 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 includes fertility preservation services, see Fertility Preservation section. |
| If you need help recovering or have other special health needs | Home health care | Not Applicable | 20% coinsurance | 50% coinsurance | \$75 maximum/visit for Non- Network Providers . 100 visits/year for Home Health and Private Duty Nursing combined for In- Network and Non- Network Providers combined. |
| | Rehabilitation services | Not Applicable | \$30/visit deductible does not apply | 50% coinsurance | *See Therapy Services section. |
| | Habilitation services | Not Applicable | \$30/visit deductible does not apply | 50% coinsurance | |
| | Skilled nursing care | Not Applicable | 20% coinsurance | 50% coinsurance | \$150 maximum/day for Non- Network Providers . 100 days/benefit period for skilled nursing services for In- Network and Non- Network Providers combined. |
| | Durable medical equipment | Not Applicable | 50% coinsurance | 50% coinsurance | *See Durable Medical Equipment Section |
| | 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 | \$0 copayment up to plan's Maximum Allowed Amount | *See Vision Services section |

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/ca/5SYUSMG01012021>.

| 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) | |
| | Children's glasses | Not Applicable | No charge | \$0 <u>copayment</u> up to <u>plan's Maximum Allowed Amount</u> | |
| | Children's dental check-up | Not Applicable | 0% <u>coinsurance</u> | 0% <u>coinsurance</u> | *See Dental Services section |

Excluded Services & Other Covered Services:

| Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .) | | |
|--|---|--|
| <ul style="list-style-type: none"> • Cosmetic surgery • Infertility treatment • Weight loss programs | <ul style="list-style-type: none"> • Dental care (Adult) • Long-term care | <ul style="list-style-type: none"> • Hearing aids • Routine foot care unless medically necessary |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.) | | |
|---|---|---|
| <ul style="list-style-type: none"> • Acupuncture • Most coverage provided outside the United States. See www.bcbsglobalcore.com | <ul style="list-style-type: none"> • Bariatric surgery • Private-duty nursing 100 visits/year combined with Home Health | <ul style="list-style-type: none"> • Chiropractic care 20 visits/year • 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 Managed Health Care, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, (888) 466-2219, <https://www.dmhca.ca.gov/>, Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), 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 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

* For more information about limitations and exceptions, see plan or policy document at <https://eoc.anthem.com/eocdps/ca/5SYUSMG01012021>.

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/5SYUSMG01012021>.

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) | | Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition) | | Mia's Simple Fracture (in-network emergency room visit and follow up care) | |
|--|-----------------|--|----------------|--|----------------|
| ■ The plan's overall deductible | \$750 | ■ The plan's overall deductible | \$750 | ■ The plan's overall deductible | \$750 |
| ■ Specialist copayment | \$55 | ■ Specialist copayment | \$55 | ■ Specialist copayment | \$55 |
| ■ Hospital (facility) coinsurance | 20% | ■ Hospital (facility) coinsurance | 20% | ■ Hospital (facility) coinsurance | 20% |
| ■ Other copayment | \$15 | ■ Other copayment | \$15 | ■ Other copayment | \$15 |
| <p>This EXAMPLE event includes services like:</p> <p>Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)</p> | | <p>This EXAMPLE event includes services like:</p> <p>Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)</p> | | <p>This EXAMPLE event includes services like:</p> <p>Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)</p> | |
| Total Example Cost | \$12,700 | Total Example Cost | \$5,600 | Total Example Cost | \$2,800 |
| In this example, Peg would pay: | | In this example, Joe would pay: | | In this example, Mia would pay: | |
| Cost Sharing | | Cost Sharing | | Cost Sharing | |
| Deductibles | \$750 | Deductibles | \$300 | Deductibles | \$750 |
| Copayments | \$300 | Copayments | \$1,600 | Copayments | \$300 |
| Coinsurance | \$2,100 | Coinsurance | \$0 | Coinsurance | \$300 |
| <i>What isn't covered</i> | | <i>What isn't covered</i> | | <i>What isn't covered</i> | |
| Limits or exclusions | \$60 | Limits or exclusions | \$20 | Limits or exclusions | \$0 |
| The total Peg would pay is | \$3,210 | The total Joe would pay is | \$1,920 | The total Mia would pay is | \$1,350 |

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 bɛ̀ bédjé b́á céè-djè nìà kɛ dyí ní, ɔ̀ m̀ò nì dyí-bédjèin-djè b́é m̀ kɛ gbo-kpá-kpá kè b̄́ kp̄́ djé m̀ b́ídjí-wùdùùn b́ó pídyi. B́é m̀ kɛ wuɖu-zìin-nyò djò gbo wùdù kɛ, djá (855) 383-7248.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্য 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 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.

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): O bụr u na i nwere ajuju o bula gbasara akwukwo a, i nwere ikike inweta enyemaka na ozi n'asusu gi na akwughị ugwo o bula. Ka gi na okowa okwu kwuo okwu, kpoo (855) 383-7248.

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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

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Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។
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Lao (ພາສາລາວ): ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.
ເພື່ອໂອ້ນລັບກ່ຽວກັບພາສາ, ໃຫ້ໂທຫາ (855) 383-7248.

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Nepali (नेपाली): यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ।
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