




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/3KCRSMG01012019>. 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 ?	\$1,350 /person or \$2,700 /family for In- Network Providers . \$2,700 /person or \$5,400 /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 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. \$325 /person or \$650 /family for Prescription Drugs In- Network Providers . 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 ?	\$7,900 /person or \$15,800 /family for In- Network Providers . \$15,800 /person or \$31,600 /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, Advantage PPO. See www.anthem.com/ca or call (855) 383-7248 for a list of network providers .	You pay the least if you use a provider in Preferred Network . You pay more if you use a 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

1/01/2019

		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	\$40/visit deductible does not apply	50% coinsurance	-----none-----
	Specialist visit	Not Applicable	\$80/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)	Not Applicable	40% coinsurance	50% coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)	Not Applicable	40% coinsurance	50% coinsurance	\$380 maximum/admission for Non- Network Providers .
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.anthem.com/pharmacyinformation/	Tier 1a - Typically Lower Cost Generic	Not Applicable	\$5/prescription, Prescription Drug deductible does not apply (retail) and \$13/prescription, Prescription Drug deductible does not apply (home delivery)	Not covered (retail) and Not covered (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).
	Tier 1b - Typically Generic	Not Applicable	\$20/prescription, Prescription Drug deductible does not	Not covered (retail) and Not covered (home delivery)	

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/ca/3KCRSMG01012019>.

Common Medical Event	Services You May Need	What You Will Pay 1/01/2019			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)	
Select Drug List			apply (retail) and \$50/prescription, Prescription Drug <u>deductible</u> does not apply (home delivery)		
	Tier 2 - Typically <u>Preferred</u> Brand & Non- <u>Preferred</u> Generic Drugs	Not Applicable	\$50/prescription, Prescription Drug <u>deductible</u> applies (retail) and \$150/prescription, Prescription Drug <u>deductible</u> applies (home delivery)	Not covered (retail) and Not covered (home delivery)	
	Tier 3 - Typically Non- <u>Preferred</u> Brand and Generic drugs	Not Applicable	\$90/prescription, Prescription Drug <u>deductible</u> applies (retail) and \$270/prescription, Prescription Drug <u>deductible</u> applies (home delivery)	Not covered (retail) and Not covered (home delivery)	
	Tier 4 - Typically <u>Preferred Specialty</u> (brand and generic)	Not Applicable	30% <u>coinsurance</u> up to \$250/prescription, Prescription Drug <u>deductible</u> applies (retail and home delivery)	Not covered (retail) and Not covered (home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% <u>coinsurance</u>	40% <u>coinsurance</u> then \$250/visit	50% <u>coinsurance</u>	\$380 maximum benefit/admission for Non- <u>Network Providers</u> . -----none-----
	Physician/surgeon fees	Not Applicable	40% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need	<u>Emergency room care</u>	Not Applicable	\$350/visit then	Covered as In-	Copay waived if admitted.

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Common Medical Event	Services You May Need	What You Will Pay 1/01/2019			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)	
immediate medical attention	Emergency medical transportation	Not Applicable	40% coinsurance	Network Covered as In- Network	-----none-----
	Urgent care	Not Applicable	\$80/visit deductible does not apply	50% coinsurance	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	40% coinsurance then \$500/admission	50% coinsurance	\$650 maximum benefit/day for Non- Network Providers .100 days/benefit period for 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	Not Applicable	Office Visit \$40/visit deductible does not apply Other Outpatient 40% coinsurance	Office Visit 50% coinsurance Other Outpatient 50% coinsurance	Office Visit -----none----- Other Outpatient -----none-----
	Inpatient services	40% coinsurance	40% coinsurance then \$500/admission	50% coinsurance	\$650 maximum benefit/day for Non- Network Providers .40% 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. \$40/visit deductible does not apply for Postnatal Preferred Network Providers . Not covered for Postnatal In- Network Providers . 50% coinsurance for Postnatal Non- Network Providers .In- Network preventative prenatal
	Childbirth/delivery professional services	Not Applicable	40% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	40% coinsurance	40% coinsurance then \$500/admission	50% coinsurance	

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/ca/3KCRSMG01012019>.

Common Medical Event	Services You May Need	What You Will Pay 1/01/2019			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)	
					and postnatal services are covered at 100%. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
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/year for Home Health and Private Duty Nursing 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 then \$500/admission	50% coinsurance	\$150 maximum benefit/day for Non- Network Providers .100 days/benefit period for Inpatient rehabilitation and skilled nursing services 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	\$0/visit, deductible does not apply	\$0 copayment up to plan's Maximum Allowed Amount	*See Vision Services section
	Children's glasses	Not Applicable	\$0/unit, deductible does not apply	\$0 copayment up to plan's Maximum Allowed Amount	
	Children's dental check-up	Not Applicable	No charge	No charge	*See Dental Services section

Excluded Services & Other Covered Services:

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

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/ca/3KCRSMG01012019>.

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

- Acupuncture
- Infertility treatment Limited to Medically Necessary iatrogenic fertility preservation services.
- Routine eye care (Adult) 1 exam/benefit period.
- Bariatric surgery
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Chiropractic care 20 visits/year
- Private-duty nursing 100 visits/year combined with Home Health

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) HMO-2219. 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

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, 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/3KCRSMG01012019>.



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)																																										
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<p>This EXAMPLE event includes services like:</p> <ul style="list-style-type: none"> 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>This EXAMPLE event includes services like:</p> <ul style="list-style-type: none"> 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>This EXAMPLE event includes services like:</p> <ul style="list-style-type: none"> 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>) 																																										
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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።

. (855) 383-7248 **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 bá céè-djè nià ke dyí ní, ɔ̀ m̀ò ni dyí-bédjèin-djè bɛ̀ m̀ ké gbo-kpá-kpá kè b̄́ kp̄́ djé m̀ bídjí-wùdùùn b́ó pídyi. Bɛ̀ m̀ ké wuɖu-zìin-nyò d̀ò gbo wùdù ke, d́á (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 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.

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