




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/3KCZSMG01012019>. 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 ?	\$1,700 /person or \$3,400 /family for In- Network Providers . \$3,400 /person or \$6,800 /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. \$350 /person or \$700 /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, Select PPO. See www.anthem.com/ca or call (855) 383-7248 for a list of network providers .	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 plan

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		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
		In-Network Provider (You will pay the least)	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	\$45/visit deductible does not apply	50% coinsurance	-----none-----
	Specialist visit	\$90/visit deductible does not apply	50% coinsurance	-----none-----
	Preventive care / screening / immunization	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)	35% coinsurance	50% coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)	35% coinsurance then \$100/procedure	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/ Select Drug List	Tier 1a - Typically Lower Cost Generic	\$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	\$20/prescription, Prescription Drug deductible does not apply (retail) and \$50/prescription, Prescription Drug deductible does not apply (home delivery)	Not covered (retail) and Not covered (home delivery)	
	Tier 2 - Typically Preferred Brand & Non- Preferred Generic Drugs	\$50/prescription, Prescription Drug deductible applies (retail) and \$150/prescription, Prescription Drug deductible applies (home delivery)	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/3KCZSMG01012019>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Tier 3 - Typically Non- <u>Preferred</u> Brand and Generic drugs	\$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)	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)	\$300/visit then 35% <u>coinsurance</u>	50% <u>coinsurance</u>	\$380 maximum benefit/admission for Non- <u>Network Providers</u> .
	Physician/surgeon fees	35% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
If you need immediate medical attention	<u>Emergency room care</u>	\$300/visit then 35% <u>coinsurance</u>	Covered as In- <u>Network</u>	Copay waived if admitted.35% <u>coinsurance</u> for Emergency Room Physician Fee.
	<u>Emergency medical transportation</u>	35% <u>coinsurance</u>	Covered as In- <u>Network</u>	-----none-----
	<u>Urgent care</u>	\$90/visit <u>deductible</u> does not apply	50% <u>coinsurance</u>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	\$750/admission	50% <u>coinsurance</u>	\$650 maximum benefit/day for Non- <u>Network Providers</u> .100 days/benefit period for Inpatient rehabilitation and skilled nursing services combined.
	Physician/surgeon fees	35% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit \$45/visit <u>deductible</u> does not apply Other Outpatient 35% <u>coinsurance</u>	Office Visit 50% <u>coinsurance</u> Other Outpatient 50% <u>coinsurance</u>	Office Visit -----none----- Other Outpatient -----none-----
	Inpatient services	\$750/admission	50% <u>coinsurance</u>	\$650 maximum benefit/day for Non- <u>Network Providers</u> .0% <u>coinsurance</u> for Inpatient Physician Fee In- <u>Network</u>

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/ca/3KCZSMG01012019>.

Common Medical Event	Services You May Need	What You Will Pay 1/01/2019		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
				<u>Providers</u> . 50% <u>coinsurance</u> for Inpatient Physician Fee Non- <u>Network Providers</u> .
If you are pregnant	Office visits	No charge	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for preventive services. \$45/visit <u>deductible</u> does not apply for Postnatal In- <u>Network Providers</u> . In- <u>Network</u> preventative prenatal and postnatal services are covered at 100%. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	35% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$750/admission	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	35% <u>coinsurance</u>	50% <u>coinsurance</u>	\$75 maximum benefit/visit for Non- <u>Network Providers</u> .100 visits/year for Home Health and Private Duty Nursing combined.
	<u>Rehabilitation services</u>	35% <u>coinsurance</u>	50% <u>coinsurance</u>	*See Therapy Services section
	<u>Habilitation services</u>	35% <u>coinsurance</u>	50% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	\$750/admission	50% <u>coinsurance</u>	\$150 maximum benefit/day for Non- <u>Network Providers</u> .100 days/benefit period for Inpatient rehabilitation and skilled nursing services combined.
	<u>Durable medical equipment</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	*See <u>Durable Medical Equipment</u> Section
	<u>Hospice services</u>	0% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
If your child needs dental or eye care	Children's eye exam	\$0/visit, <u>deductible</u> does not apply	\$0 <u>copayment</u> up to <u>plan's</u> Maximum <u>Allowed Amount</u>	*See Vision Services section
	Children's glasses	\$0/unit, <u>deductible</u> does not apply	\$0 <u>copayment</u> up to <u>plan's</u> Maximum <u>Allowed Amount</u>	
	Children's dental check-up	No charge	No charge	*See Dental Services section

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/ca/3KCZSMG01012019>.

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
- Long-term care
- Dental care (Adult)
- Routine foot care unless medically necessary
- Hearing aids
- Weight loss programs

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

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/ca/3KCZSMG01012019>.

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](#).

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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/3KCZSMG01012019>.



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>) 																																										
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Total Example Cost</td> <td style="text-align: right;">\$12,800</td> </tr> </table>	Total Example Cost	\$12,800	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Total Example Cost</td> <td style="text-align: right;">\$7,400</td> </tr> </table>	Total Example Cost	\$7,400	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Total Example Cost</td> <td style="text-align: right;">\$1,900</td> </tr> </table>	Total Example Cost	\$1,900																																				
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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 b̄é bédjé bá céè-djè n̄à ke dyí ní, ɔ̀ m̀ò n̄i dyí-b̄édjèin-djè b̄é m̄ ké gbo-kpá-kpá kè b̄ɔ̀ kpɔ̀ djé m̄ bídjí-wùdùùn b̄ó pídyi. B̄é m̄ ké wuɖu-zìin-nyò d̀ò gbo wùdù ke, d̀á (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 n̄ɔŋ thiëc n̄e ke de yā thorē, ke yin n̄ɔŋ loŋ b̄e yi kuony ku w̄er al̄eu b̄e ḡeɛr yic yin ne thoŋ du ke cin w̄eu tāauē ke piny. Te k̄or yin ba jam w̄enē ran ye thok geryic, ke yin c̄ol (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.

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