




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/aso>. 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 1-888-722-1077 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$1,500/individual or \$3,000/family for all 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 for In- 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. \$500 for hospital admission if services not preauthorized. 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 ?	Yes. \$6,000/individual or \$12,000/family for In- Network Providers . \$12,000/individual or \$24,000/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 ?	Penalty for non-preauthorized hospital stay, Premiums , Balanced-Billed 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, Blue Card PPO. See www.anthem.com/ca or call 1-888-722-1077 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 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.

Important Questions	Answers	Why This Matters:
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)	Out-of-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	\$25/visit	40% coinsurance	-----none-----
	Specialist visit	\$40/visit	40% coinsurance	-----none-----
	Preventive care/screening /immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Pre-certification may be required.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Pre-certification may be required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.[insert] .	Tier 1 - Typically Generic	Retail: \$10/prescription Mail Order: \$20/prescription	Retail: Not covered except if required as a result of an emergency or urgently needed service for an acute condition. Mail Order: Not covered	30-day supply limit for retail. 90-day supply limit for mail order.
	Tier 2 - Typically Preferred / Brand	Retail: \$30/prescription Mail Order: \$60/prescription		30-day supply limit for specialty drugs (retail or mail order). Mail Order Subject to Market Based Pricing
	Tier 3 - Typically Non-Preferred / Specialty Drugs	Retail: \$50/prescription Mail Order: \$100/prescription		Deductible: n/a Benefit Maximum: n/a Lifetime Maximum: n/a
	Tier 4 - Typically Specialty Drugs	Retail: \$50/prescription Mail order: \$50/prescription		Maximum Out of Pocket for Specialty drugs: \$2,000 per participant.
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	-----none-----

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
surgery	Physician/surgeon fees	20% coinsurance	40% coinsurance	-----none-----
If you need immediate medical attention	Emergency room care	\$200/visit then 20% coinsurance deductible does not apply	Covered as In- Network	Copay waived if admitted. Pre-certification may be required.
	Emergency medical transportation	20% coinsurance	Covered as In- Network	-----none-----
	Urgent care	\$75/visit	Covered as In- Network	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Pre-certification required.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	-----none-----
If you need mental health, behavioral health, or substance abuse needs	Outpatient services	Office Visit \$40/visit Other Outpatient \$40/visit	Office Visit 40% coinsurance Other Outpatient 40% coinsurance	-----none-----
	Inpatient services	20% coinsurance	40% coinsurance	Pre-certification required.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	-----none-----
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	120 visits/calendar year. One visit equals 4 hours or less.
	Rehabilitation services	\$40/visit	40% coinsurance	Physical Therapy, Physical Medicine & Occupational Therapy limited to 24 visits per calendar year.
	Habilitation services	\$40/visit	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	120 days limit/calendar year.
	Durable medical equipment	20% coinsurance	40% coinsurance	Pre-certification may be required.
	Hospice service	30% coinsurance	30% coinsurance	Inpatient or outpatient services for members with up to one year life expectancy.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	-----none-----
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

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

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services .)		
<ul style="list-style-type: none">• Direct Abortion• Cosmetic surgery• Infertility treatment• Routine eye care (adult)	<ul style="list-style-type: none">• Dental care (adult)• Long-term care• Routine foot care unless you have been diagnosed with diabetes	<ul style="list-style-type: none">• Hearing aids• Private-duty nursing• Weight loss programs• Non-emergency coverage provided outside the United States. See www.bcbsglobalcore.com
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none">• Chiropractic care 24 visits/calendar year.• LiveHealth Online – consultations using the internet via webcam for general medicine or behavioral health visits www.livehealthonline.com	<ul style="list-style-type: none">• Acupuncture 12 visits/calendar year.• Emergency coverage provided outside the United States. See www.bcbsglobalcore.com	<ul style="list-style-type: none">• Bariatric surgery for morbid obesity only.

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 1-866-444-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:

Attn: **Grievance** and **Appeals**, P.O. Box 54159, Los Angeles, CA 90054-0519

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

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.-----

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	\$1,500
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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	\$12,738
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$90
Coinsurance	\$2,480
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,130

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

■ The plan's overall deductible	\$1,500
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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	\$7,400
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$980
Coinsurance	\$372
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$2,908

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

■ The plan's overall deductible	\$1,500
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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	\$1,925
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$916
Copayments	\$480
Coinsurance	\$229
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,625

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 (888) 722-1077

Amharic (አማርኛ):- ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (888) 722-1077 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 (888) 722-1077.

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՝ (888) 722-1077 :

Bassa (Básó Wùdù): M̄ dyi dyi-diè-dɛ b̄é b̄édé b̄á céè-dɛ nià kɛ dyí ní, ɔ m̄ò ni dyí-b̄édè̀in-dɛ b̄é m̄ k̄é gbo-kpá-kpá k̄è b̄ǐ kp̄ǒ d̄é m̄ bídí-wùdù̀un b̄ó pídyi. B̄é m̄ k̄é wuɖu-zìin-nyò d̄ò gbo wùdù kɛ, d̄á (888) 722-1077.

Bengali (বাংলা): যদি এই তথ্য পুস্তিকার বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য কল করুন (888) 722-1077

Burmese (ပြန်စာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (888) 722-1077 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 (888) 722-1077。

Dinka (Dinka): Na n̄ɔŋ thiëc n̄e ke de yā thorë, ke yin n̄ɔŋ loŋ b̄e yi kuony ku w̄er alëu b̄e ḡeɛr yic yin ne thoŋ du ke cin w̄eu tāäuë ke piny. Te k̄or yin ba jam w̄ënë ran ye thok geryic, ke yin c̄ol (888) 722-1077.

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 (888) 722-1077.

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 (888) 722-1077 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 (888) 722-1077.

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 (888) 722-1077.

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 (888) 722-1077.

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 (888) 722-1077.

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 (888) 722-1077.

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 (888) 722-1077 ।

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 (888) 722-1077.

Igbo (Igbo): O bụrụ 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 (888) 722-1077.

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 (888) 722-1077.

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 (888) 722-1077.

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 (888) 722-1077

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、(888) 722-1077 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។
ដើម្បីជ្រកជាមួយអ្នកបកប្រែ សូមហៅ (888) 722-1077 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata gicro. Kugira uvugishe umusemuzi, akura (888) 722-1077 .

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (888) 722-1077 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.
ເພື່ອໂອ້ນລັກກັບວ່າມແບພາສາ, ໃຫ້ໂທຫາ (888) 722-1077.

Navajo (Diné): Dít naaltsoos biká'ígíí lahgo bina'idíłkídgó ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjı́ bee nił hodoonih t'áadoo báąh ílínígóó.
Ata' halne'ígíí la' bich'ı́' hadeesdzih nínízingo koǰı́' hodiılnih (888) 722-1077.

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