The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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, <u>https://eoc.anthem.com/eocdps/aso</u>. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms, see the Glossary. You can view the Glossary at <u>www.healthcare.gov/sbc-glossary/</u> or call (833) 807-1875 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	 \$0/single or \$0/family for In- <u>Network Providers</u>. \$2,000/single or \$6,000/family for Out-of-<u>Network Providers</u>. 	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible?</u>	No.	You will have to meet the <u>deductible</u> before the <u>plan</u> pays for any services.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-</u> <u>pocket limit</u> for this <u>plan</u> ?	 \$1,500/single or \$4,500/family for In-<u>Network Providers</u>. \$5,000/single or \$15,000/family for Out-of-<u>Network Providers</u>. 	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket</u> <u>limit</u> ?	Premiums, balance-billing charges, and health care this plan_doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network</u> <u>provider</u> ?	Yes. Blue Card PPO. See <u>www.anthem.com/ca</u> or call (833) 807-1875 for a list of <u>network providers.</u> Costs may vary by site of service and how the provider bills.	This plan uses a provider network. You will pay less if you use a provider in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>Out-of-Network</u> <u>Provider</u> for some services (such as lab work). Check with your provider before you get services.

All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

Common		What You	Limitations, Exceptions, & Other Important Information		
Medical Event	Services You May Need	In-Network ProviderOut-of-Network Provider(You will pay the least)(You will pay the most)			
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$15/visit	30% coinsurance	Virtual visits (Telehealth) benefits available.	
	<u>Specialist</u> visit	\$30/visit	30% coinsurance	Virtual visits (Telehealth) benefits available.	
	Preventive care/screening/ immunization	No charge	30% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your <u>plan</u> will pay for.	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance	none	
	Imaging (CT/PET scans, MRIs)	No charge	30% coinsurance	none	
If you need drugs to treat your illness or condition More information about <u>prescription</u> <u>drug coverage</u> is available at <u>http://www.anthe</u> m.com/ca/pharma cyinformation/	Tier 1 - Typically Generic	\$10/prescription (retail) and \$20/prescription (home delivery)	Not covered (retail and home delivery)	Most home delivery is 90-day	
	Tier 2 - Typically Preferred Brand & Non-Preferred Generic Drugs	\$20/prescription (retail) and \$40/prescription (home delivery)	Not covered (retail and home delivery)	supply. For more information, refer to "National Drug List" at http://www.anthem.com/ca/ph armacyinformation/ *See Prescription Drug section of the plan or policy document (e.g. evidence of coverage or certificate).	
	Tier 3 - Typically Non-Preferred Brand and Generic drugs	\$35/prescription (retail) and \$70/prescription (home delivery)	Not covered (retail and home delivery)		
	Tier 4 - Typically Preferred Specialty (brand and generic)	\$35/prescription (retail) and \$70/prescription (home delivery)	Not covered (retail and home delivery)		
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance	none	
surgery	Physician/surgeon fees	No charge	30% coinsurance	none	
If you need immediate medical attention	Emergency room care	\$150/visit	Covered as In- <u>Network</u>	Copay waived if admitted. No charge for Emergency Room Physician Fee.	
	Emergency medical transportation	No charge	No charge for ground ambulance and air ambulance.	\$2,000 maximum/transport for ground ambulance and \$20,000	

Common		What You			
Medical Event	Services You May Need	In-Network ProviderOut-of-Network Provider(You will pay the least)(You will pay the model)			
				for air ambulance Out-of- <u>Network Providers</u> .	
	<u>Urgent care</u>	\$15/visit	Covered as In- <u>Network</u>	none	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% <u>coinsurance</u>	60 days/benefit period for Inpatient rehabilitation and skilled nursing services combined.	
	Physician/surgeon fees	No charge	30% <u>coinsurance</u>	none	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit \$15/visit Other Outpatient \$15/visit	Office Visit 10% <u>coinsurance</u> Other Outpatient 10% <u>coinsurance</u>	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient none	
	Inpatient services	No charge	10% <u>coinsurance</u>	No charge for Inpatient Physician Fee In- <u>Network</u> <u>Providers</u> . 10% <u>coinsurance</u> for Inpatient Physician Fee Out-of- <u>Network Providers</u> .	
	Office visits	\$15/visit for the first 1 visit	30% <u>coinsurance</u>		
If you are	Childbirth/delivery professional services	No charge	30% coinsurance	Maternity care may include tests and services described elsewhere	
pregnant	Childbirth/delivery facility services	No charge	30% coinsurance	in the SBC (i.e. ultrasound).	
Home health care No cha	No charge	30% <u>coinsurance</u>	120 visits/benefit period.		
	Rehabilitation services	\$30/visit	30% coinsurance	60 visit limit/benefit period,	
If you need help recovering or have other special health needs	Habilitation services	\$30/visit	30% coinsurance	combined for therapy services. *See Therapy Services section.	
	Skilled nursing care	No charge	30% coinsurance	60 days/benefit period for Inpatient rehabilitation and skilled nursing services combined.	
	Durable medical equipment	No charge	30% coinsurance	*See <u>Durable Medical</u> <u>Equipment</u> Section	
	Hospice services	No charge	30% <u>coinsurance</u>	12 months or less to live.	
	Children's eye exam	Not covered	Not covered	none	
	Children's glasses	Not covered	Not covered	none	

Common		What You	What You Will Pay		
Common Medical Event	Services You May Need	In- <u>Network</u> <u>Provider</u> (You will pay the least)	Out-of- <u>Network Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information	
If your child					
needs dental or eye care	Children's dental check-up	Not covered	Not covered	none	
Excluded Services	& Other Covered Services:				
Services Your <u>Plan</u> excluded services.)	•	Check your policy or <u>plan</u> docume	nt for more information and	a list of any other	
Cosmetic surgery		Dental care (Adult) Dental Care (Adult)		Theck-up	
• Eye exams for a child		Glasses for a child Long-ter		m care	
• Routine eye care (Adult)		 Routine foot care unless you have been diagnosed with diabetes Weight less 		oss programs	
Other Covered Ser	vices (Limitations may apply to	o these services. This isn't a comp	lete list. Please see your <u>plan</u>	document.)	
Hearing aids monthsPrivate-duty	e 30 visits/benefit period \$\$4,000 maximum/24 nursing only covered in the visits/benefit period	 Bariatric surgery for In-<u>Netwo</u> <u>Providers</u> Infertility treatment \$30,000 m lifetime 	Most cov	ctic care 30 days/benefit period verage provided outside the United ee <u>www.bcbsglobalcore.com</u>	

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, 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 <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. 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

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

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes <u>plans</u>, <u>health insurance</u> available through the <u>Marketplace</u> or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of <u>Minimum Essential Coverage</u>, you may not be eligible for the <u>premium tax credit</u>.

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 <u>plan</u> 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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost</u> <u>sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>deductible</u> <u>Specialist copayment</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> This EXAMPLE event includes servi like: 	\$0 \$30 0% 0% ces	 The plan's overall <u>deductible</u> <u>Specialist copayment</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> This EXAMPLE event includes servilike: 	\$0 \$30 0% 0%	 The plan's overall <u>deductible</u> <u>Specialist copayment</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> This EXAMPLE event includes services like: 	
<u>Specialist</u> office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (<i>ultrasounds and blood work</i>) <u>Specialist</u> visit (<i>anesthesia</i>)		Primary care physician office visits (including disease education) Diagnostic tests (blood work) Prescription drugs Durable medical equipment (glucose meter)		Emergency room care (including medical supplies) Diagnostic test (x-ray) Durable medical equipment (crutches) Rehabilitation services (physical therapy)	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay: <u>Cost Sharing</u>		In this example, Joe would pay: <u>Cost Sharing</u>		In this example, Mia would pay: <u>Cost Sharing</u>	
Deductibles	\$0	Deductibles	\$0	Deductibles	\$0
<u>Copayments</u>	\$10	<u>Copayments</u>	\$1,000	<u>Copayments</u>	\$400
Coinsurance	\$0	<u>Coinsurance</u>	\$0	<u>Coinsurance</u>	\$0
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0
The total Peg would pay is	\$70	The total Joe would pay is	\$1,020	The total Mia would pay is	\$400

The <u>plan</u> 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 1-888-254-2721

Amharic (አጣርኛ): ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን ሞረጃ በነጻ የማግኘት ሞብት አለዎት። አስተርዓሚ ለማና<mark>ንር</mark> 1-888-254-2721 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 2721-254-1888 -

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվձար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով։ Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ 1-888-254-2721։

Bassa (Băsóð Wùdù): À dyi dyi-diè-dè bě bédé bá céè-dè nìà kɛ dyí ní, ɔ mò nì dyí-bèdèìn-dè bé m≀ ké gbo-kpá-kpá kè bỗ kpõ dé m≀ bídí-wùdùǔn bó pídyi. Bé m≀ ké wudu-ziìn-nyò dò gbo wùdù kɛ, dá 1-888-254-2721.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, ভাহলে আপনার ভাষায় বিনামূল্য সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা ব্লার জন্য 1-888-254-2721 –তে কল করুন।

Burmese **(မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖု 1-888-254-2721 သို့ ခေါ် ဆိုပါ။

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1-888-254-2721。

Dinka (Dinka): Na noŋ thiêëc në ke de yä thorë, ke yin noŋ loŋ bë yi kuony ku wɛr alëu bë gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kor yin ba jam wënë ran ye thok geryic, ke yin col 1-888-254-2721.

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 1-888-254-2721.

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 1-888-254-254 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 1-888-254-2721.

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 1-888-254-2721.

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 1-888-254-2721.

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 1-888-254-2721.

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 1-888-254-2721.

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 करें1-888-254-2721 ।

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 1-888-254-2721.

Igbo (Igbo): O bụr ụ na ị nwere ajujụ o bụla gbasara akwukwo a, į nwere ikike inweta enyemaka na ozi n'asụsụ gi na akwughi ụgwo o bụla. Ka gi na okowa okwu kwuo okwu, kpoo 1-888-254-2721.

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 1-888-254-2721.

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 1-888-254-2721.

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 1-888-254-2721

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、1-888-254-2721 にお電話ください。

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Khmer (ខ្មែរ)៖ បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ1-888-254-2721 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura 1-888-254-2721.

Korean (**한국어**): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면1-888-254-2721 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄຳຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອໂອ້ລົມກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ 1-888-254-2721.

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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। दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् 1-888-254-2721

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