




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/8ZXDSMG01012026>. 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/](http://www.healthcare.gov/sbc-glossary/) or call (855) 383-7248 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	\$2,500/person or \$5,000/family for In-Network Providers. \$5,000/person or \$10,000/family for Out-of-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.
<b>Are there services covered before you meet your deductible?</b>	Yes. Primary Care. Specialist Visit. Preventive Care. Dental. Vision. For more information see below.	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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	Yes. \$300/person or \$600/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.
<b>What is the out-of-pocket limit for this plan?</b>	\$8,600/person or \$17,200/family for In-Network Providers. \$17,200/person or \$34,400/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.
<b>What is not included in the out-of-pocket limit?</b>	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.
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.anthem.com/find-care/?alphaprefix=JQY">www.anthem.com/find-care/?alphaprefix=JQY</a> or call (855) 383-7248 for a list of network providers. Benefits and	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

	costs may vary by site of service and how the <u>provider</u> bills.	<u>Provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$55/visit, <u>deductible</u> does not apply	50% <u>coinsurance</u>	Virtual visits (Telehealth) benefits available.
	<u>Specialist</u> visit	\$90/visit, <u>deductible</u> does not apply	50% <u>coinsurance</u>	Virtual visits (Telehealth) benefits available.
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	50% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	Lab – Office \$55/visit, <u>deductible</u> does not apply X-Ray – Office \$90/visit, <u>deductible</u> does not apply	Lab – Office 50% <u>coinsurance</u> X-Ray – Office 50% <u>coinsurance</u>	-----none-----
	Imaging (CT/PET scans, MRIs)	35% <u>coinsurance</u>	50% <u>coinsurance</u>	\$380 maximum/admission for <u>Out-of-Network Providers</u> .
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a>	Typically Generic (Tier 1)	\$20/prescription, Prescription Drug <u>deductible</u> does not apply (retail) and \$40/prescription, Prescription Drug <u>deductible</u> does not apply (home delivery)	Not covered (retail and home delivery)	Most home delivery is 90-day supply. For more information, refer to “Select Drug List” at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a> *See <u>Prescription Drug</u> section of the <u>plan</u> or policy document (e.g. evidence of coverage or certificate).
	Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 2)	\$75/prescription, Prescription Drug <u>deductible</u> applies (retail) and \$188/prescription, Prescription Drug <u>deductible</u> applies (home delivery)	Not covered (retail and home delivery)	
	Typically Non-Preferred Brand and Generic drugs (Tier 3)	\$105/prescription, Prescription Drug <u>deductible</u> applies (retail) and	Not covered (retail and home delivery)	

\* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/ca/8ZXDSMG01012026>.

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)	
		\$263/prescription, Prescription Drug <u>deductible</u> applies (home delivery)		
	Typically Preferred <u>Specialty</u> (brand and generic) (Tier 4)	30% <u>coinsurance</u> up to \$250/prescription, Prescription Drug <u>deductible</u> applies (retail and home delivery)	Not covered (retail and home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	35% <u>coinsurance</u>	50% <u>coinsurance</u>	\$380 maximum/admission for <u>Out-of-Network Providers</u> .
	Physician/surgeon fees	35% <u>coinsurance</u> , <u>deductible</u> does not apply	50% <u>coinsurance</u>	-----none-----
If you need immediate medical attention	<u>Emergency room care</u>	35% <u>coinsurance</u>	Covered as In- <u>Network</u>	No charge 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>	\$55/visit, <u>deductible</u> does not apply	50% <u>coinsurance</u>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	35% <u>coinsurance</u>	50% <u>coinsurance</u>	\$650 maximum/day for <u>Out-of-Network Providers</u> .
	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 \$55/visit, <u>deductible</u> does not apply Other Outpatient 35% <u>coinsurance</u> , <u>deductible</u> does not apply, up to a \$55 maximum	Office Visit 50% <u>coinsurance</u> Other Outpatient 50% <u>coinsurance</u>	Office Visit 988 lifeline/mobile crisis team covered as In- <u>Network</u> . Virtual visits (Telehealth) benefits available. Other Outpatient -----none-----
	Inpatient services	35% <u>coinsurance</u>	50% <u>coinsurance</u>	\$650 maximum/day for <u>Out-of-Network Providers</u> . 35% <u>coinsurance</u> for Inpatient Physician Fee In- <u>Network</u> Providers. 50% <u>coinsurance</u> for Inpatient Physician Fee <u>Out-of-Network Providers</u> .
	Office visits	No charge	50% <u>coinsurance</u>	

\* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/ca/8ZXDSMG01012026>.

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 are pregnant	Childbirth/delivery professional services	35% <u>coinsurance</u>	50% <u>coinsurance</u>	Cost sharing does not apply for <u>preventive services</u> . \$55/visit, <u>deductible</u> does not apply for Postpartum In-Network Providers. In-Network preventative prenatal and postpartum 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.
	Childbirth/delivery facility services	35% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	35% <u>coinsurance</u> , <u>deductible</u> does not apply	50% <u>coinsurance</u>	\$75 maximum/visit for <u>Out-of-Network Providers</u> . 100 visits/year for Home Health and Private Duty Nursing combined.
	<u>Rehabilitation services</u>	\$55/visit, <u>deductible</u> does not apply	50% <u>coinsurance</u>	
	<u>Habilitation services</u>	\$55/visit, <u>deductible</u> does not apply	50% <u>coinsurance</u>	*See Therapy Services section.
	<u>Skilled nursing care</u>	35% <u>coinsurance</u>	50% <u>coinsurance</u>	\$150 maximum/day for <u>Out-of-Network Providers</u> . 100 days/benefit period for Inpatient physical medicine, rehabilitation including day rehabilitation programs and skilled nursing services combined.
	<u>Durable medical equipment</u>	35% <u>coinsurance</u> , <u>deductible</u> does not apply	50% <u>coinsurance</u>	*See <u>Durable Medical Equipment</u> section.
	<u>Hospice services</u>	No charge	50% <u>coinsurance</u>	-----none-----
If your child needs dental or eye care	Children's eye exam	No charge	\$0 <u>copayment</u> up to <u>plan's Maximum Allowed Amount</u>	*See Vision Services section.
	Children's glasses	No charge	\$0 <u>copayment</u> up to <u>plan's Maximum Allowed Amount</u>	
	Children's dental check-up	No charge	No charge	*See Dental Services section.

\* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/ca/8ZXDSMG01012026>.

## 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.)

- Chiropractic care
- Hearing aids
- Routine foot care unless medically necessary
- Cosmetic surgery
- Infertility treatment
- Weight loss programs
- Dental care (Adult)
- Long-term care

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

- Acupuncture (In-Network)
- Private-duty nursing 100 visits/year combined with Home Health
- Bariatric surgery (In-Network)
- Routine eye care (Adult) 1 exam/benefit period
- Most coverage provided outside the United States. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)

**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](http://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](http://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 on how 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](http://www.dol.gov/ebsa/healthreform)

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/>

Additionally, a consumer assistance program can help you file your appeal. Contact California Consumer Assistance Program, Operated by the California Department of Managed Health Care, 980 9th Street, 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.*

## 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 <u>plan's</u> overall <u>deductible</u>	\$2,500	■ The <u>plan's</u> overall <u>deductible</u>	\$2,500	■ The <u>plan's</u> overall <u>deductible</u>	\$2,500
■ <u>Specialist copayment</u>	\$90	■ <u>Specialist copayment</u>	\$90	■ <u>Specialist copayment</u>	\$90
■ <u>Hospital (facility) coinsurance</u>	35%	■ <u>Hospital (facility) coinsurance</u>	35%	■ <u>Hospital (facility) coinsurance</u>	35%
■ <u>Other copayment</u>	\$55	■ <u>Other copayment</u>	\$55	■ <u>Other copayment</u>	\$55
<p>This EXAMPLE event includes services like:</p> <p><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>)</p>		<p>This EXAMPLE event includes services like:</p> <p><u>Primary care physician</u> office visits (<i>including disease education</i>)  <u>Diagnostic tests</u> (<i>blood work</i>)            Prescription drugs  <u>Durable medical equipment</u> (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like:</p> <p><u>Emergency room care</u> (<i>including medical supplies</i>)  <u>Diagnostic test</u> (<i>x-ray</i>)  <u>Durable medical equipment</u> (<i>crutches</i>)  <u>Rehabilitation services</u> (<i>physical therapy</i>)</p>	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Peg would pay:</b>		<b>In this example, Joe would pay:</b>		<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
<u>Deductibles</u>	\$2,500	<u>Deductibles</u>	\$300	<u>Deductibles</u>	\$1,300
<u>Copayments</u>	\$700	<u>Copayments</u>	\$2,300	<u>Copayments</u>	\$600
<u>Coinsurance</u>	\$3,000	<u>Coinsurance</u>	\$0	<u>Coinsurance</u>	\$90
<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
<b>The total Peg would pay is</b>	<b>\$6,260</b>	<b>The total Joe would pay is</b>	<b>\$2,620</b>	<b>The total Mia would pay is</b>	<b>\$1,990</b>

The plan would be responsible for the other costs of these EXAMPLE covered services.

## Get help in your language

### Language Assistance Services

Curious to know what all this says? We would be too. Here's the English version: **IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD:711)**

Separate from our language assistance program, we make documents available in alternative formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

### Spanish

**IMPORTANTE:** ¿Puede leer esta carta? Si no, podemos pedirle a alguien que le ayude a leerla. También es posible que pueda solicitar que le enviemos esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721 (TTY/TDD: 711).

### Arabic

هام: هل تستطيع قراءة هذه الرسالة؟ إذا لم يكن الأمر كذلك، يمكننا أن نطلب من شخص ما مساعدتك في قراءتها. قد تتمكن أيضاً من الحصول على هذه الرسالة مكتوبة بلغتك للحصول على مساعدة مجانية، يرجى الاتصال على الفور على الرقم 1-888-254-2721. (TTY/TDD: 711)

### Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք կարդալ այս նամակը: Եթե ոչ, մենք կարող ենք առաջարկել որևէ մեկի օգնությունը՝ ձեզ համար այն կարդալու համար: Դուք կարող եք նաև այս նամակը ստանալ ձեր լեզվով: Անվճար օգնության համար խնդրում ենք անմիջապես զանգահարել՝ 1-888-254-2721. (TTY/TDD: 711)

### Chinese

重要：您能看此信嗎？如果不能，我們可以請人幫您看。您還可以獲得以您的語言寫的此信件。如需免費幫助，請立即致電 1-888-254-2721. (TTY/TDD:711)

### Farsi

بخواهیم شخصی از توانیم می ما، توانیدنی اگر بخوانید؟ را نامه این توانید می آیا مهم: کتبی صورت به را نامه این بتوانید است ممکن همچنین. کند کمک شما به آن خواندن در شماره با فوراً لطفاً، رایگان کمک دریافت برای. کنید دریافت خودتان زبان به و بگیرید تماس (1-888-254-2721. (TTY/TDD: 711)

### Hindi

महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में किसी की मदद ले सकते हैं। यह पत्र आप अपनी भाषा में भी लिखवा सकते हैं। निःशुल्क सहायता के लिए, कृपया तुरंत 1-888-254-2721 पर कॉल करें। (टीटीवाई/टीडीडी:711)

### Hmong

TSEEM CEEB: Koj puas nyeem tau daim ntawv no? Yog tias tsis tau, peb muaj qee tus neeg pab nyeem nws rau koj. Koj los kuj yuav tau txais ib daim ntawv sau ua kom yam lus. Rau kev pab dawb, thov hu tam sim ntawm 1-888-254-2721. (TTY/TDD: 711)

### Japanese

重要：この文書を読むことができますか？読むことができない場合、支援することが可能です。また、日本語で訳されたこの文書を書面で受け取ることができます。無料の支援をご希望の場合、1-888-254-2721 (TTY/TDD:711) にご連絡ください。

**Khmer**

សំខាន់៖ តើអ្នកអាចអានសំបុត្រនេះបានទេ? បើអត់ទេ យើងអាចមានអ្នកជួយអាន។ អ្នកក៏អាចទទួលបានសំបុត្រនេះសរសេរជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយ ឥតគិតថ្លៃ សូមទូរស័ព្ទមកភ្លាមៗតាមរយៈលេខ 1-888-254-2721. (TTY/TDD: 711)

**Korean**

중요: 이 편지를 읽으실 수 있으신가요? 그렇지 않으신 경우, 이를 읽으실 수 있도록 도움을 제공해 드릴 수 있습니다. 귀하의 모국어로 된 편지를 우편으로 받아보실 수도 있습니다. 무상으로 제공되는 도움이 필요하신 경우, 1-888-254-2721번으로 바로 연락해 주십시오. (TTY/TDD: 711)

**Punjabi**

ਕੀ ਤੁਸੀਂ ਇਹ ਚਿੱਠੀ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਸ ਚਿੱਠੀ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵੀ ਲਿਖ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਤੁਰੰਤ ਇਸ 'ਤੇ ਕਾਲ ਕਰੋ 1-888-254-2721। (TTY/TDD: 711)

**Russian**

ВАЖНАЯ ИНФОРМАЦИЯ: Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

**Tagalog**

MAHALAGA: Mababasa mo ba ang sulat na ito? Kung hindi, mayroon kaming makakatulong sa iyo na basahin ito. Maaari mo ring makuha ang sulat na ito nang nakasulat sa iyong wika. Para sa libheng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

**Thai**

สำคัญ: คุณสามารถอ่านจดหมายนี้ได้หรือไม่ หากคุณอ่านจดหมายนี้ไม่ได้ เราสามารถขอให้ ใครสักคนช่วยคุณอ่านได้ คุณสามารถร้องขอ จดหมายนี้ที่เขียนในภาษาของคุณได้เช่นกัน หากต้องการความช่วยเหลือแบบไม่มีค่าใช้จ่าย โปรดโทรหาเราได้ที่ 1-888-254-2721. (TTY/TDD: 711)

**Vietnamese**

QUAN TRỌNG: Quý vị có đọc được lá thư này không? Nếu không, chúng tôi có thể nhờ ai đó giúp quý vị đọc. Quý vị cũng có thể yêu cầu thư này viết bằng ngôn ngữ của quý vị. Để được trợ giúp miễn phí, hãy gọi ngay đến số 1-888-254-2721. (TTY/TDD: 711)

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