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 (855) 333-5730 to request a copy. For your Pharmacy benefits through Express-Scripts (Medco) go to www.express-scripts.com or call 1-877-554-3091.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$300**/single or **$900**/family for In-Network Providers. **$600**/single or **$1,800**/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. Preventive care for In-Network and Non-Network Providers. Primary Care visit and Specialist visit 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$5,300**/single or **$10,600**/family. All Providers Prescription (Only In-network Provides): **$1,300**/single or **$2,600**/family.	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, Prudent Buyer PPO. See www.anthem.com/ca or call (800) 967-3015 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.

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	$20/visit deductible does not apply	10% coinsurance	--------none--------
	Specialist visit	$20/visit deductible does not apply	10% coinsurance	--------none--------
	Preventive care/screening/ immunization	No charge	No charge	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)	10% coinsurance	10% coinsurance	--------none--------
	Imaging (CT/PET scans, MRIs)	10% coinsurance	10% coinsurance	Coverage for Out-of-Network Provider is limited to $800 maximum per test.
Pharmacy OOPM	Out of Pocket Maximum (OOPM)	**$1,300** Per Individual/ **$2,600** Per Family	Non-Network claims do not apply to the OOPM	Member penalties including generic equivalent and retail refill allowance do not apply to the OOPM.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Tier 1 - Typically Generic	$10 Co-pay (retail) $10 Co-pay (mail order)	$10 Co-pay (retail) Not Covered for mail order scripts	Covers up to a 30-day supply (retail prescription); up to a 90-day supply (mail order prescription). For brand drugs that have a generic equivalent available: Member may pay the generic co-pay plus the difference in cost between the brand and generic drugs. For prepackaged drugs that have more than a 30 day supply, members will be charged up to 3 co-pays at a retail pharmacy per fill.
	Tier 2 - Typically Preferred / Brand	$25 Co-pay (retail) $25 Co-pay (mail order)	$25Co-pay (retail) Not Covered for mail order scripts	

* For more information about limitations and exceptions, see **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)	Non-Network Provider (You will pay the most)	
	Tier 3 - Typically Non-Preferred / Specialty Drugs	$45 Co-pay (retail) $45 Co-pay (mail order)	$45 Co-pay (retail) Not Covered for mail order scripts	Prior Authorization / Coverage Management programs may apply to some drugs. Retail fill allowance: The first three times that you purchase a long-term drug at a participating retail pharmacy, you'll pay your retail co- payment. After the third purchase, you'll pay a higher cost if you continue to purchase it at retail. Out of Pocket Maximum (OOPM) Member penalties including generic equivalent and retail refill allowance do not apply to the OOPM.
	Tier 4 - Typically Specialty (brand and generic)	Follows tier copays(retail) Follows tier copays (mail order)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	10% coinsurance	Coverage for Out-of-Network Provider is limited to $350 maximum per day.
	Physician/surgeon fees	10% coinsurance	10% coinsurance	--------none--------
If you need immediate medical attention	Emergency room care	10% coinsurance	Covered as In-Network	10% coinsurance for Emergency Room Physician Fee.
	Emergency medical transportation	20% coinsurance	Covered as In-Network	--------none--------
	Urgent care	$20/visit deductible does not apply	10% coinsurance	Costs may vary by site of service.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	10% coinsurance	$600 maximum/day for Non-Network Providers.
	Physician/surgeon fees	10% coinsurance	10% coinsurance	--------none--------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit $20/visit deductible does not apply Other Outpatient 10% coinsurance	Office Visit 10% coinsurance Other Outpatient 10% coinsurance	Office Visit Includes Durable Medical Equipment. Other Outpatient Includes Durable Medical Equipment. Coverage for Out-of-Network Provider is limited to $350 maximum per day.

* For more information about limitations and exceptions, see **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)	Non-Network Provider (You will pay the most)	
	Inpatient services	10% coinsurance	10% coinsurance	$600 maximum/day for Non-Network Providers. 10% coinsurance for Inpatient Physician Fee.
If you are pregnant	Office visits	$20/visit deductible does not apply	10% coinsurance	$600 maximum/day for Non-Network Providers. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	10% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	10% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	10% coinsurance	100 visits/benefit period.
	Rehabilitation services	10% coinsurance	10% coinsurance	*See Therapy Services section or Mental Health Substance Abuse section
	Habilitation services	10% coinsurance	10% coinsurance	
	Skilled nursing care	10% coinsurance	10% coinsurance	100 days limit/benefit period.
	Durable medical equipment	20% coinsurance	20% coinsurance	*See Durable medical equipment section or Mental Health Substance Abuse section for those services.
	Hospice services	10% coinsurance	10% coinsurance	--------none--------
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	*See Vision Services section
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	*See Dental Services section

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/ca/aso.

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
- Eye exams for a child
- Long- term care
- Routine foot care unless you have been diagnosed with diabetes.
- Dental care (adult)
- Glasses for a child
- Private-duty nursing
- Dental Check-up
- Weight loss programs
- Routine eye care (adult)

Pharmacy Benefit Exclusions

- Allergy Serums
- Biologicals
- Drugs used for cosmetic purposes
- Drugs used to promote or stimulate hair growth
- Blood or blood plasma products
- Insulin Pumps
- Non-Federal Legend Drugs
- Nutritional Supplements
- Ostomy Supplies
- Drugs labeled "Caution-limited by Federal law to investigational use" or experimental drugs, even though a charge is made to the individual
- Some or certain compounds are excluded
- ACA Preventive Meds Contraceptives – Exception: covered for adults less than 51 years of age
- ACA Preventive Meds Aspirin– Exception: covered for adults under 70 years of age
- ACA Preventive Meds Folic Acid- Exception: covered for adults under 51 years of age
- ACA Preventive Meds Fluoride -Exception: covered for children 6 months through 5 years of age
- ACA Preventive Meds Smoking Cessation- Exception: covered for adults 18 years of age and over
- ACA Preventive Meds - Breast Cancer Prevention, Exception: covered for adults 35 years of age and over
- ACA Preventive Meds- Bowel Prep Agents Exception: covered for adults between the ages of 50 through 75 years
- ACA Preventive Meds – Vitamin D Exception: Covered for adults age 65 years of age and over
- Certain formulary exclusions apply, for more information on this as well as the latest drug coverage please visit our website www.express-scripts.com
- ACA Preventive Meds - Statins Exception: Covered for adults 40-75 years of age

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/ca/aso.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Abortion • Chiropractic care 20 visits/benefit period. • Most coverage provided outside the United States. See www.bcbsglobalcore.com	• Acupuncture • Hearing aids one hearing aid per ear every three years.	• Bariatric surgery • Infertility treatment $5,000 maximum/lifetime
Other Pharmacy Benefit Inclusions		
• Specialty Drugs • Insulin • OTC Diabetic Supplies (except Insulin Pumps and Glucowatch products) • ACA Preventive Meds Aspirin– Exception: covered for adults under 70 years of age • ACA Preventive Meds Smoking Cessation- Exception: covered for adults 18 years of age and over • ACA Preventive Meds - Statins Exception: Covered for adults 40-75 years of age	• State Restricted Drugs • Needles and Syringes • ACA Preventive Meds Contraceptives – Exception: covered for adults less than 51 years of age • ACA Preventive Meds Folic Acid- Exception: covered for adults under 51 years of age • ACA Preventive Meds - Breast Cancer Prevention, Exception: covered for adults 35 years of age and over	• Vaccines • Drugs to treat Impotency for males only age 18 and over • ACA Preventive Meds – Vitamin D Exception: Covered for adults age 65 years of age and over • ACA Preventive Meds Fluoride -Exception: covered for children 6 months through 5 years of age • ACA Preventive Meds- Bowel Prep Agents Exception: covered for adults between the ages of 50 through 75 years

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, Employee Benefits Security Administration, (866) 444-EBSA (3272), 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: Grievances and Appeals, P.O. Box 4310, Woodland Hills, CA 91365-4310

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/ca/aso.

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

California Department of Insurance, Consumer Communications Bureau, 300 South Spring Street, South Tower, Los Angeles, CA 90013, 1-800-927-HELP (4357), 1-213-897-8921, 1-800-482-4TDD (4633), www.insurance.ca.gov/

Does this plan provide Minimum Essential Coverage? Yes/No

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/No

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/aso.

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	$300
Specialist *copayment*	$20
Hospital (facility) *coinsurance*	10%
Other *coinsurance*	10%

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$2,570**

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

The plan's overall deductible	$300
Specialist *copayment*	$20
Hospital (facility) *coinsurance*	10%
Other *coinsurance*	10%

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$4,800**

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

The plan's overall deductible	$300
Specialist *copayment*	$20
Hospital (facility) *coinsurance*	10%
Other *coinsurance*	10%

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$100
Coinsurance	$400
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$810**

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 (800) 967-3015

Amharic (አማርኛ)፦ ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (800) 967-3015 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 (800) 967-3015.

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՝ (800) 967-3015:

Bassa (Bàsɔ̀ɔ̀ Wùdù): Ǹ dyi dyi-diè-dɛ̀ bě bédé bá céè-dɛ̀ nìà kɛ dyí ní, ɔ mɔ̀ nì dyí-bèdɛ̀ìn-dɛ̀ bɛ́ m̀ ké gbo-kpá-kpá kè bɔ̌ kpɔ̃ dé m̀ bídí-wùdùǔn bó pídyi. Bé m̀ ké wudu-zììn-nyɔ̀ dò gbo wùdù kɛ, dá (800) 967-3015.

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 (800) 967-3015 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အခမဲ့အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် (800) 967-3015 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 (800) 967-3015。

Dinka (Dinka): Na nɔŋ thiëëc në ke de yä thorë, ke yin nɔŋ loŋ bë yi kuony ku wɛr alëu bë gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kɔr yin ba jam wënë ran ye thok geryic, ke yin cɔl (800) 967-3015.

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 (800) 967-3015.

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 (800) 967-3015 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 (800) 967-3015.

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 (800) 967-3015.

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 (800) 967-3015.

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 (800) 967-3015.

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 (800) 967-3015.

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 (800) 967-3015 ।

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 (800) 967-3015.

Igbo (Igbo): Ọ bụr ụ 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 (800) 967-3015.

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 (800) 967-3015.

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 (800) 967-3015.

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 (800) 967-3015

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、(800) 967-3015 にお電話ください。

Language Access Services:

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