
 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, [www.anthem.com/ca/calpers](http://www.anthem.com/ca/calpers). 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 (877) 737-7776 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	Member total of \$2,500 In Network: \$ 500 Out of Network: \$ 2,000 Family total of \$5,000 In Network: \$ 1,000 Out of Network: \$ 4,000	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> . Whichever is met first.
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Prescription Drugs</a> , <a href="#">Preventive care</a> , Primary Care visit, and <a href="#">Specialist</a> visit for PPO <a href="#">Providers</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain preventive services without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . 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 <a href="#">deductibles</a> for specific services?</b>	Yes. <b>\$250</b> /per admission for all inpatient. <b>\$50</b> / visit for <a href="#">Emergency room</a> services (waived if admitted directly from ER).	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services. <a href="#">Coinsurance</a> may apply for all other services provided in the ER.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<b>\$2,000</b> /single or <b>\$4,000</b> /family for PPO <a href="#">Providers</a> . <b>\$0</b> /single or <b>\$0</b> /family for Non-PPO <a href="#">Providers</a> . This <a href="#">plan</a> has a separate Out of Pocket Maximum for <a href="#">Prescription Drugs</a> of <b>\$2,000</b> /single or <b>\$4,000</b> /family, <b>\$1,000</b> Home delivery.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met. Whichever is met first.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, deductible, copay, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Important Questions	Answers	Why This Matters:

(cont.)		
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes, Prudent Buyer PPO. See <a href="http://www.anthem.com/ca/calpers">www.anthem.com/ca/calpers</a> or call (877) 737-7776 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an out-of- <a href="#">network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an out-of- <a href="#">network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$20/visit medical <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Specialist</a> visit	\$35/visit medical <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Preventive care/screening/immunization</a>	No charge	40% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test, x-ray</a>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Prior authorization may be required.
	Diagnostic laboratory, blood work	10% coinsurance*	40% coinsurance	* Services received at Quest Diagnostic and Labcorp Facilities are paid at 100% for in network providers. If you must travel more than 15 miles outside your services area to one of these two providers, a Laboratory Location Exception form is available.
<b>If you need drugs to treat your illness or condition</b>	Tier 1 - Typically Generic	\$5/prescription <a href="#">deductible</a> does not apply (retail) and \$10/prescription <a href="#">deductible</a> does not apply (home delivery)	Not covered	Most home delivery is 90-day supply. *See Prescription Drug section of the <a href="#">plan</a> or policy document (e.g. evidence of coverage or certificate).

\* For more information about limitations and exceptions, see [plan](#) or policy document at [www.anthem.com/ca/calpers](http://www.anthem.com/ca/calpers).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
More information about <a href="http://www.optumrx.com/calpers">prescription drug coverage</a> is available at <a href="http://www.optumrx.com/calpers">http://www.optumrx.com/calpers</a>	Tier 2 - Typically <a href="#">Preferred Brand</a>	\$20/prescription <a href="#">deductible</a> does not apply (retail) and \$40/prescription <a href="#">deductible</a> does not apply (home delivery)	Not covered	
	Tier 3 - Typically Non- <a href="#">Preferred</a> / <a href="#">Specialty Drugs</a>	\$50/prescription <a href="#">deductible</a> does not apply (retail) and \$100/prescription <a href="#">deductible</a> does not apply (home delivery)	Not covered	
	Tier 4 - Typically <a href="#">Specialty</a> (brand and generic)	<a href="#">Specialty</a> follows the tier structure above.	Not covered	
If you have outpatient surgery	Facility fee (e.g., hospital, ambulatory surgery center)	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Services and supplies for certain outpatient surgeries may be limited if not done at an ambulatory surgery center. For example: Colonoscopy limited to \$1,500 per procedure, Cataract surgery limited to \$2,000 per procedure. Check with your plan for additional details. Benefits limited to \$350 for ASC per day for Non-PPO <a href="#">providers</a> .
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
If you need immediate medical attention	<a href="#">Emergency room care</a>	10% <a href="#">coinsurance</a> Emergency room services	Covered as In- <a href="#">Network</a>	If admitted directly to hospital \$50 ER <a href="#">deductible</a> waived.
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	Covered as In- <a href="#">Network</a>	You must be taken to the nearest facility that can provide care for your condition. Ambulance services are subject to Medical Necessity reviews.
	<a href="#">Urgent care</a>	\$35/visit medical <a href="#">deductible</a> does not apply 10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Coinsurance</a> for all other services provided during visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	\$250 Inpatient hospital deductible per admission. Hip and Knee joint replacement surgery will be limited to \$35,000 per procedure. A subset of participating hospitals that meets this maximum benefit coverage is available.

\* For more information about limitations and exceptions, see [plan](#) or policy document at [www.anthem.com/ca/calpers](http://www.anthem.com/ca/calpers).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit \$20/visit medical <a href="#">deductible</a> does not apply Other Outpatient 10% <a href="#">coinsurance</a>	Office Visit 40% <a href="#">coinsurance</a> Other Outpatient 40% <a href="#">coinsurance</a>	Office Visit -----none----- Other Outpatient May require prior authorization.
	Inpatient services	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a> for Inpatient Physician Fee PPO <a href="#">Providers</a> . 40% <a href="#">coinsurance</a> for Inpatient Physician Fee Non-PPO <a href="#">Providers</a> . Prior authorization required.
If you are pregnant	Office visits	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Alternative Birthing Center may be used instead of hospitalization.
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	100 visits/benefit period. A visit is defined as 4 hours or less.
	<a href="#">Rehabilitation services</a>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	*See Therapy Services section
	<a href="#">Habilitation services</a>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a> The first 10 days. 20% <a href="#">coinsurance</a> For the next 170 days.	40% <a href="#">coinsurance</a>	180 days limit/benefit period.
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	The purchase of Durable Medical Equipment priced at \$1,000 or more requires Precertification.
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	-----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 [www.anthem.com/ca/calpers](http://www.anthem.com/ca/calpers).

## 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
- Weight loss programs
- Dental Check-up
- Infertility treatment
- Routine eye care (adult)

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

- Acupuncture Rider 20 visits/benefit period combined with Chiropractic care.
- Hearing aids \$1,000 maximum every 36 months.
- Bariatric surgery
- Most coverage provided outside the United States. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)
- Chiropractic care Rider 20 visits/benefit period combined with Acupuncture.

**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](http://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](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 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 60007, Los Angeles, CA 90060-0007

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

California Department of Managed Health Care Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814, (888) 466-2219, [www.healthhelp.ca.gov](http://www.healthhelp.ca.gov), [helpline@dmhc.ca.gov](mailto:helpline@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](#).

\* For more information about limitations and exceptions, see [plan](#) or policy document at [www.anthem.com/ca/calpers](http://www.anthem.com/ca/calpers).

**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](#) \$500
- [Specialist copayment](#) \$0
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,150
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$1,650</b>

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

- The [plan's](#) overall [deductible](#) \$500
- [Primary care 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*)

<b>Total Example Cost</b>	<b>\$2,600</b>
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In this example, Joe would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$300
<a href="#">Copayments</a>	\$120
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$440</b>

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

- The [plan's](#) overall [deductible](#) \$500
- [Emergency Room copayment](#) \$50
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$50
<a href="#">Coinsurance</a>	\$390
<i>What isn't covered</i>	
Limits or exclusions	\$100
<b>The total Mia would pay is</b>	<b>\$1,040</b>

\* For more information about limitations and exceptions, see [plan](#) or policy document at [www.anthem.com/ca/calpers](http://www.anthem.com/ca/calpers).

## 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 (877) 737-7776

**Amharic (አማርኛ):-** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (877) 737-7776 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 (877) 737-7776.

**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՝ (877) 737-7776:

**Bassa (Bàsɔ̀ Wùdù):** M̄ dyi dyi-diè-djè b̄ě b̄édjé b̄á céè-djè nià ke dyí ní, ɔ̀ m̄ò ni dyí-b̄èd̄jè-in-djè b̄é m̄ ké gbo-kpá-kpá kè b̄ǎ kp̄ǎ djé m̄ bídí-wùdùùn b̄ó pídyi. B̄é m̄ ké wuɖu-zìin-nyò d̄ò gbo wùdù ke, d̄á (877) 737-7776.

**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 (877) 737-7776 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (877) 737-7776 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 (877) 737-7776。

**Dinka (Dinka):** Na nɔŋ thiëc në ke de yā thorë, ke yin nɔŋ loŋ bē yi kuony ku wër alëu bē gɛɛr yic yin ne thoŋ du ke cin wëu tāäuë ke piny. Te kør yin ba jam wënë ran ye thok geryic, ke yin cöl (877) 737-7776.

**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 (877) 737-7776.

**Farsi (فارسی):** 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 (877) 737-7776 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 (877) 737-7776.

## 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 (877) 737-7776.

**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 (877) 737-7776.

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