



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, you can get the complete terms in the policy or plan document at [www.anthem.com/ca/sisc](http://www.anthem.com/ca/sisc) or by calling 1-855-333-5730. 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 1-855-333-5730 to request a copy.

| Important Questions                                                | Answers                                                                                                                                                   | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall deductible?</b>                             | \$200 per individual / \$500 per family. Does not apply to <u>preventative care</u> and <u>prescription drugs</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> .                                                                                                                                                                 |
| <b>Are there services covered before you meet your deductible?</b> | Yes. <u>Preventative care</u> and primary care services are covered before you meet your <u>deductible</u>                                                | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> 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, <u>prescription drug coverage deductible</u> : \$200 per individual / \$500 per family. Does not apply to generic drugs.                             | You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>What is the out-of-pocket limit for this plan?</b>              | For <u>network providers</u> : \$1,000 individual / \$3,000 family for medical. \$2,500 individual / \$3,500 family for <u>prescription drug coverage</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.                                                                                                                                                                                                                                                                                     |
| <b>What is not included in the out-of-pocket limit?</b>            | <u>Copayments</u> for certain services, <u>premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.                 | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Will you pay less if you use a network provider?</b>            | Yes. For a list of <u>network providers</u> , see <a href="http://www.anthem.com/ca/sisc">www.anthem.com/ca/sisc</a> or call 1-855-333-5730.              | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's 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 <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| <b>Do you need a referral to see a specialist?</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                                                                                                                                                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                     |                                                  | <u>Network Provider</u><br>(You will pay the least)                                             | <u>Out-of-network provider</u><br>(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 | \$0 / visit (first three visits)<br>\$20 / visit thereafter<br><u>Deductible</u> does not apply | Billed charges exceeding <u>out-of-network</u> fee schedule.                                                                                      | None                                                                                                                                                                                                         |
|                                                                                                                                                                                                     | <u>Specialist</u> Visit                          | \$20 / visit<br><u>Deductible</u> does not apply                                                | Billed charges exceeding <u>out-of-network</u> fee schedule.                                                                                      | None                                                                                                                                                                                                         |
|                                                                                                                                                                                                     | <u>Preventive care/screening/immunization</u>    | No Charge<br><u>Deductible</u> does not apply                                                   | Not Covered                                                                                                                                       | None                                                                                                                                                                                                         |
| <b>If you have a test</b>                                                                                                                                                                           | <u>Diagnostic test</u> (x-ray, blood work)       | 20% <u>coinsurance</u>                                                                          | Not Covered                                                                                                                                       | None                                                                                                                                                                                                         |
|                                                                                                                                                                                                     | Imaging (CT/PET scans, MRIs)                     | 20% <u>coinsurance</u>                                                                          | Billed charges exceeding <u>out-of-network</u> fee schedule.                                                                                      | Coverage limited to \$800 for <u>out-of-network providers</u> .                                                                                                                                              |
| <b>If you need drugs to treat your illness or condition</b><br><b>More information about <u>prescription drug coverage</u> is available at <a href="http://www.navitus.com">www.navitus.com</a></b> | Generic drugs                                    | Retail 30-Days:<br>Costco: \$0/Rx<br>Other: \$10/Rx<br>Mail 90-Days: \$0/Rx                     | Member must pay the entire cost up front and apply for reimbursement. Net cost may be greater than if member uses an <u>in-network provider</u> . | Some narcotic pain medications and cough medications require the regular retail <u>copayment</u> at Costco and 3 times the regular <u>copayment</u> at Mail.                                                 |
|                                                                                                                                                                                                     | Preferred brand drugs                            | Retail 30-Days:<br>Costco: \$35/Rx<br>Other: \$35/Rx<br>Mail 90-Days: \$90/Rx                   |                                                                                                                                                   | If a brand drug is dispensed when a generic equivalent is available, then the member will be responsible for the generic <u>copayment</u> plus the cost difference between the generic and brand.            |
|                                                                                                                                                                                                     | <u>Specialty drugs</u>                           | 30-Days: \$35/Rx                                                                                | Not Covered                                                                                                                                       | Member must use Navitus Specialty Rx. Supplies of more than 30 days are not allowed                                                                                                                          |
| <b>If you have outpatient surgery</b>                                                                                                                                                               | Facility fee (e.g., ambulatory surgery center)   | 20% <u>coinsurance</u>                                                                          | Billed charges exceeding <u>out-of-network</u> fee schedule.                                                                                      | <u>In-network</u> hospital benefit limitations:<br>Arthroscopy: \$4,500/procedure<br>Cataract Surgery: \$2,000/procedure<br>Colonoscopy: \$1,500/procedure<br>Upper GI Endoscopy w/Biopsy: \$1,250/procedure |

| Common Medical Event                                                      | Services You May Need                   | What You Will Pay                                                                                  |                                                              | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                               |
|---------------------------------------------------------------------------|-----------------------------------------|----------------------------------------------------------------------------------------------------|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                         | Network Provider<br>(You will pay the least)                                                       | Out-of-network provider<br>(You will pay the most)           |                                                                                                                                                                                                                                                                      |
|                                                                           |                                         |                                                                                                    |                                                              | Upper GI Endoscopy w/o Biopsy:<br>\$1,000/procedure<br><br>Coverage is limited to \$350/day for <u>out-of-network</u> Ambulatory Surgery Centers.                                                                                                                    |
|                                                                           | Physician/surgeon fees                  | 20% <u>coinsurance</u>                                                                             | Billed charges exceeding <u>out-of-network</u> fee schedule. | None                                                                                                                                                                                                                                                                 |
| If you need immediate medical attention                                   | <u>Emergency room care</u>              | \$100 / visit<br>+20% <u>coinsurance</u>                                                           | \$100 / visit<br>+20% <u>coinsurance</u>                     | \$100 <u>Copayment</u> waived if admitted. You are responsible for billed charges exceeding maximum <u>allowed amount</u> for <u>out-of-network providers</u> .                                                                                                      |
|                                                                           | <u>Emergency medical transportation</u> | \$100 / trip<br>+20% <u>coinsurance</u>                                                            | \$100 / trip<br>+20% <u>coinsurance</u>                      | None                                                                                                                                                                                                                                                                 |
|                                                                           | <u>Urgent care</u>                      | \$20 / visit<br><u>Deductible</u> does not apply                                                   | Billed charges exceeding <u>out-of-network</u> fee schedule. | None                                                                                                                                                                                                                                                                 |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)      | 20% <u>coinsurance</u>                                                                             | Billed charges exceeding <u>out-of-network</u> fee schedule. | The maximum <u>plan</u> payment for non-emergency hospital services received from a non-preferred hospital is \$600 per day. Members are responsible for all charges in excess of \$600. Failure to prior authorize may result in reduced or nonpayment of benefits. |
|                                                                           | Physician/surgeon fees                  | 20% <u>coinsurance</u>                                                                             | Billed charges exceeding <u>out-of-network</u> fee schedule. | None                                                                                                                                                                                                                                                                 |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                     | Office Visit: \$20 / visit<br><u>Deductible</u> does not apply<br>Facility: 20% <u>coinsurance</u> | Billed charges exceeding <u>out-of-network</u> fee schedule. | None                                                                                                                                                                                                                                                                 |
|                                                                           | Inpatient services                      | 20% <u>coinsurance</u>                                                                             | Billed charges exceeding <u>out-of-network</u> fee schedule. | This is for facility professional services only. Please refer to your hospital stay for facility fee.                                                                                                                                                                |
| If you are pregnant                                                       | Office visits                           | \$20 / visit<br><u>Deductible</u> does not apply                                                   | Billed charges exceeding <u>out-of-network</u> fee schedule. | <u>Cost sharing</u> does not apply for <u>preventative services</u> . Depending on                                                                                                                                                                                   |

| Common Medical Event                                           | Services You May Need                     | What You Will Pay                                   |                                                              | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                      |
|----------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                           | <u>Network Provider</u><br>(You will pay the least) | <u>Out-of-network provider</u><br>(You will pay the most)    |                                                                                                                                                                                                                                                                                                                                                             |
|                                                                |                                           |                                                     |                                                              | the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)                                                                                                                                                             |
|                                                                | Childbirth/delivery professional services | 20% <u>coinsurance</u>                              | Billed charges exceeding <u>out-of-network</u> fee schedule. | None                                                                                                                                                                                                                                                                                                                                                        |
|                                                                | Childbirth/delivery facility services     | 20% <u>coinsurance</u>                              | Billed charges exceeding <u>out-of-network</u> fee schedule. | Non-Preferred facility are subject to a maximum benefit payment up to \$600 per day.                                                                                                                                                                                                                                                                        |
| If you need help recovering or have other special health needs | <u>Home health care</u>                   | 20% <u>coinsurance</u>                              | Billed charges exceeding <u>out-of-network</u> fee schedule. | Coverage is limited to a total of 100 visits, <u>In-network Provider</u> and <u>Non-Network Provider</u> combined per calendar year (one visit by a home health aide equals four hours or less; not covered while member receives hospice care). <u>In-network</u> and <u>Non-Network</u> services count towards your limit. Subject to utilization review. |
|                                                                | <u>Rehabilitation services</u>            | 20% <u>coinsurance</u>                              | Not Covered                                                  | Subject to <u>medical necessity</u> review administered by American Specialty Health (ASH).                                                                                                                                                                                                                                                                 |
|                                                                | <u>Habilitation services</u>              | 20% <u>coinsurance</u>                              | Not Covered                                                  |                                                                                                                                                                                                                                                                                                                                                             |
|                                                                | <u>Skilled nursing care</u>               | 20% <u>coinsurance</u>                              | Billed charges exceeding <u>out-of-network</u> fee schedule. | Coverage for Inpatient rehabilitation and skilled nursing services is limited to a combined total of 150 days per calendar year for services received from <u>In-network &amp; Non-Network providers</u> . For <u>Non-Network providers</u> , limited \$600/Day. Subject to utilization review.                                                             |
|                                                                | <u>Durable medical equipment</u>          | 20% <u>coinsurance</u>                              | Not Covered                                                  | Subject to utilization review. Therapeutic shoes & inserts for members with diabetes (2 pairs each/calendar year).                                                                                                                                                                                                                                          |

| Common Medical Event                          | Services You May Need      | What You Will Pay                                   |                                                              | Limitations, Exceptions, & Other Important Information |
|-----------------------------------------------|----------------------------|-----------------------------------------------------|--------------------------------------------------------------|--------------------------------------------------------|
|                                               |                            | <u>Network Provider</u><br>(You will pay the least) | <u>Out-of-network provider</u><br>(You will pay the most)    |                                                        |
|                                               | <u>Hospice services</u>    | No Charge                                           | Billed charges exceeding <u>out-of-network</u> fee schedule. | None                                                   |
| <b>If your child needs dental or eye care</b> | Children's eye exam        | Not Covered                                         | Not Covered                                                  | None                                                   |
|                                               | Children's glasses         | Not Covered                                         | Not Covered                                                  | None                                                   |
|                                               | Children's dental check-up | Not Covered                                         | Not Covered                                                  | None                                                   |

## Excluded services & Other Covered Services:

| Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .) |                         |                                                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------|
| • Cosmetic surgery                                                                                                                                                     | • Long-term care        | • Routine eye care (Adult/Child)                 |
| • Dental care (Adult/Child)                                                                                                                                            | • Routine foot care     | • Services not deemed <u>medically necessary</u> |
| • Infertility treatment                                                                                                                                                | • Private -duty nursing | • Weight loss programs                           |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)                                    |                         |                                                  |
| • Acupuncture                                                                                                                                                          | • Bariatric surgery     | • Chiropractic care                              |
| • Hearing aids                                                                                                                                                         |                         |                                                  |

**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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [cciio.cms.gov](https://cciio.cms.gov). 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](https://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:

Anthem BlueCross  
ATTN: Appeals  
P.O. Box 4310  
Woodland Hills, CA 91365-4310

Or Contact: Department of Labor's Employee Benefits  
Security Administration at  
1-866-444-EBSA(3272) or  
[www.dol.gov/ebsa/healthreform](https://www.dol.gov/ebsa/healthreform)

### 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.

### Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoolwoí íínizinigo t'áá diné k'éjígó, t'áá shoodí ba na'aln'íhí ya sidáhí bich'í naabídílküid. Eí doo biigha daago ni ba'nija'go ho'aalagú bich'í hodiilní. Hai'daa iini'taago eíya, t'áá shoodí diné ya atáh halne'ígú ní bécsh bee hane'í wólta' bí'ki si'núilígú bí'kéhgo bich'í hodiilní.

아직 가입하지 않았거나 한국어로 된 도움말이 필요한 경우 영업 관리자나 그룹 관리자에게 문의하시기 바랍니다. 이미 가입한 경우 ID 카드에 있는 번호를 사용하여 고객 서비스에 문의하시기 바랍니다.

Nếu quý vị chưa phải là một hội viên và cần được giúp đỡ bằng Tiếng Việt, xin liên lạc với đại diện thương mại của quý vị hoặc quản trị viên nhóm. Nếu quý vị đã ghi danh, xin liên lạc với dịch vụ khách hàng qua việc dùng số điện thoại ghi trên thẻ ID của quý vị.

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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## 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 <u>plan's</u> overall <u>deductible</u> | \$200 |
| ■ <u>Specialist copayment</u>                 | \$20  |
| ■ Hospital (facility) <u>coinsurance</u>      | 20%   |
| ■ Other <u>coinsurance</u>                    | 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

**In this example, Peg would pay:**

| <u>Cost sharing</u> |       |
|---------------------|-------|
| <u>Deductibles</u>  | \$200 |
| <u>Copayments</u>   | \$20  |
| <u>Coinsurance</u>  | \$780 |

| <u>What isn't covered</u>         |                |
|-----------------------------------|----------------|
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$1,060</b> |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                               |       |
|-----------------------------------------------|-------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$200 |
| ■ <u>Specialist copayment</u>                 | \$20  |
| ■ Hospital (facility) <u>coinsurance</u>      | 20%   |
| ■ Other <u>coinsurance</u>                    | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

**In this example, Joe would pay:**

| <u>Cost sharing</u> |       |
|---------------------|-------|
| <u>Deductibles</u>  | \$100 |
| <u>Copayments</u>   | \$900 |
| <u>Coinsurance</u>  | \$0   |

| <u>What isn't covered</u>         |                |
|-----------------------------------|----------------|
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,020</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                               |       |
|-----------------------------------------------|-------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$200 |
| ■ <u>Specialist copayment</u>                 | \$20  |
| ■ Hospital (facility) <u>coinsurance</u>      | 20%   |
| ■ Other <u>coinsurance</u>                    | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

**In this example, Mia would pay:**

| <u>Cost sharing</u> |       |
|---------------------|-------|
| <u>Deductibles</u>  | \$200 |
| <u>Copayments</u>   | \$210 |
| <u>Coinsurance</u>  | \$500 |

| <u>What isn't covered</u>         |              |
|-----------------------------------|--------------|
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$910</b> |

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