**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 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 or call 1-855-333-5730 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $1,000 per individual / $2,000 per family. Does not apply to preventative care and prescription drugs. | 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. Preventative care, primary care, and prescription drug coverage services are covered before you meet your deductible | 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 must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | For network providers: $3,000 individual / $6,000 family for medical. $2,500 individual / $3,500 family for prescription drug coverage | 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?** | Copayments for certain services, 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. For a list of network providers, see www.anthem.com/ca/sisc or call 1-855-333-5730. | 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 |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-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 | $0 / visit (first three visits)<br>$30 / visit thereafter<br>Deductible does not apply | Billed charges exceeding out-of-network fee schedule. | None |
| | Specialist Visit | $30 / visit<br>Deductible does not apply | Billed charges exceeding out-of-network fee schedule. | None |
| | Preventive care/screening/ immunization | No Charge<br>Deductible does not apply | Not Covered | None |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | Not Covered | None |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | Billed charges exceeding out-of-network fee schedule. | Coverage limited to $800 for out-of-network providers. |
| **If you need drugs to treat your illness or condition**<br>**More information about prescription drug coverage is available at www.navitus.com** | Generic drugs | Retail 30-Days:<br>Costco: $0/Rx<br>Other: $9/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 in-network provider. | Some narcotic pain medications and cough medications require the regular retail copayment at Costco and 3 times the regular copayment 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 copayment plus the cost difference between the generic and brand. |
| | Specialty drugs | 30-Days: $35/Rx | Not Covered | Member must use Navitus Specialty Rx. Supplies of more than 30 days are not allowed |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | Billed charges exceeding out-of-network fee schedule. | In-network 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 (You will pay the least) | Out-of-network provider (You will pay the most) | |
| | | | | Upper GI Endoscopy w/o Biopsy: $1,000/procedure<br><br>Coverage is limited to $350/day for out-of-network Ambulatory Surgery Centers. |
| | Physician/surgeon fees | 20% coinsurance | Billed charges exceeding out-of-network fee schedule. | None |
| **If you need immediate medical attention** | Emergency room care | $100 / visit<br>+20% coinsurance | $100 / visit<br>+20% coinsurance | $100 Copayment waived if admitted. You are responsible for billed charges exceeding maximum allowed amount for out-of-network providers. |
| | Emergency medical transportation | $100 / trip<br>+20% coinsurance | $100 / trip<br>+20% coinsurance | None |
| | Urgent care | $30 / visit<br>Deductible does not apply | Billed charges exceeding out-of-network fee schedule. | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | Billed charges exceeding out-of-network fee schedule. | The maximum plan 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% coinsurance | Billed charges exceeding out-of-network fee schedule. | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office Visit: $30 / visit<br>Deductible does not apply<br>Facility: 20% coinsurance | Billed charges exceeding out-of-network fee schedule. | None |
| | Inpatient services | 20% coinsurance | Billed charges exceeding out-of-network fee schedule. | This is for facility professional services only. Please refer to your hospital stay for facility fee. |
| **If you are pregnant** | Office visits | $30 / visit<br>Deductible does not apply | Billed charges exceeding out-of-network fee schedule. | Cost sharing does not apply for preventative services. Depending on |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-network provider (You will pay the most) | |
| | | | | the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
| | Childbirth/delivery professional services | 20% coinsurance | Billed charges exceeding out-of-network fee schedule. | None |
| | Childbirth/delivery facility services | 20% coinsurance | Billed charges exceeding out-of-network 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** | Home health care | 20% coinsurance | Billed charges exceeding out-of-network fee schedule. | Coverage is limited to a total of 100 visits, In-network Provider and Non-Network Provider combined per calendar year (one visit by a home health aide equals four hours or less; not covered while member receives hospice care). In-network and Non-Network services count towards your limit. Subject to utilization review. |
| | Rehabilitation services | 20% coinsurance | Not Covered | Subject to medical necessity review administered by American Specialty Health (ASH). |
| | Habilitation services | 20% coinsurance | Not Covered | |
| | Skilled nursing care | 20% coinsurance | Billed charges exceeding out-of-network 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 In-network & Non-Network providers. For Non-Network providers, limited $600/Day. Subject to utilization review. |
| | Durable medical equipment | 20% coinsurance | 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 |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-network provider (You will pay the most) | |
| | Hospice services | No Charge | Billed charges exceeding out-of-network fee schedule. | None |
| **If your child needs dental or eye care** | 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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.) | | |
|---|---|---|
| • Cosmetic surgery | • Long-term care | • Routine eye care (Adult/Child) |
| • Dental care (Adult/Child) | • Routine foot care | • Services not deemed medically necessary |
| • 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 plan 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. 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 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

**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 adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíílkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į 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 mãi 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 plan's overall deductible** **$1,000**
- **Specialist copayment** **$30**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **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)*

| **Total Example Cost** | **$12,700** |
|---|---|

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

| *Cost sharing* | |
|---|---|
| Deductibles | $1,000 |
| Copayments | $20 |
| Coinsurance | $1,980 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,060** |

### Managing Joe's Type 2 Diabetes

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

- **The plan's overall deductible** **$1,000**
- **Specialist copayment** **$30**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **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)*

| **Total Example Cost** | **$5,600** |
|---|---|

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

| *Cost sharing* | |
|---|---|
| Deductibles | $100 |
| Copayments | $930 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,050** |

### Mia's Simple Fracture

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

- **The plan's overall deductible** **$1,000**
- **Specialist copayment** **$30**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **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)*

| **Total Example Cost** | **$2,800** |
|---|---|

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

| *Cost sharing* | |
|---|---|
| Deductibles | $1,000 |
| Copayments | $210 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,510** |

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