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/0L9ZIND01012027. 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 (833) 913-2233 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$5,800/person or $11,600/family for In-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. Primary Care. Preventive Care. Dental. Vision. For more information see below.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $450/person or $900/family for Prescription Drugs In-Network Providers. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$11,650/person or $23,300/family for In-Network Providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges (unless balanced billing is prohibited), 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. See www.anthem.com/find-care/?alphaprefix=JQL or call (833) 913-2233 for a list of network providers. Benefits and costs may vary by site of service and how the provider bills.	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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$60/visit, deductible does not apply	Not covered	Virtual visits (Telehealth) benefits available.
	Specialist visit	$100/visit for the first 3 visits; deductible does not apply, then $100/visit	Not covered	All office visit copayments count towards the same 3 visit limit. Virtual visits (Telehealth) benefits available.
	Preventive care/screening/ immunization	No charge, deductible does not apply	Not covered	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)	Lab – Office $50/day, deductible does not apply X-Ray – Office 40% coinsurance	Lab – Office Not covered X-Ray – Office Not covered	--------none--------
	Imaging (CT/PET scans, MRIs)	40% coinsurance	Not covered	--------none--------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.anthem.com/ca/pharmacy-information/.	Typically Generic (Tier 1)	$20/prescription, Prescription Drug deductible does not apply (retail) and $60/prescription, Prescription Drug deductible does not apply (home delivery)	Not covered (retail and home delivery)	Most home delivery is 90-day supply. For more information, refer to "CA Select IND Drug List" at https://www.anthem.com/ca/pharmacy-information/. *See Prescription Drug section of the plan or policy document (e.g. evidence of coverage or certificate).
	Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 2)	40% coinsurance up to $500/prescription, Prescription Drug deductible applies (retail) and 40% coinsurance up to $1,500/prescription, Prescription Drug deductible applies (home delivery)	Not covered (retail and home delivery)	
	Typically Non-Preferred Brand and Generic drugs (Tier 3)	40% coinsurance up to $500/prescription,	Not covered (retail and home delivery)	

* For more information about limitations and exceptions, see the plan or policy document at https://eoc.anthem.com/eocdps/ca/0L9ZIND01012027.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Prescription Drug deductible applies (retail) and 40% coinsurance up to $1,500/prescription, Prescription Drug deductible applies (home delivery)		
	Typically Preferred Specialty (brand and generic) (Tier 4)	40% coinsurance up to $500/prescription, Prescription Drug deductible applies (retail) and 40% coinsurance up to $1,500/prescription, Prescription Drug deductible applies (home delivery)	Not covered (retail and home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	Not covered	--------none--------
	Physician/surgeon fees	40% coinsurance	Not covered	--------none--------
If you need immediate medical attention	Emergency room care	40% coinsurance	Covered as In-Network	Coinsurance and deductible waived if admitted. No charge for Emergency Room Physician Fee.
	Emergency medical transportation	40% coinsurance	Covered as In-Network	Non-emergency Out-of-Network water Ambulance Services are limited to $50,000 per trip, does not apply to ground or air ambulance.
	Urgent care	$60/visit, deductible does not apply	Covered as In-Network	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	Not covered	--------none--------
	Physician/surgeon fees	40% coinsurance	Not covered	--------none--------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit $60/visit, deductible does not apply Other Outpatient 40% coinsurance, deductible does not apply, up to a $60 maximum	Office Visit Not covered Other Outpatient Not covered	Office Visit 988 lifeline/mobile crisis team covered as In-Network. Virtual visits (Telehealth) benefits available. Other Outpatient --------none--------

* For more information about limitations and exceptions, see the plan or policy document at https://eoc.anthem.com/eocdps/ca/0L9ZIND01012027.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Inpatient services	40% coinsurance	Not covered	40% coinsurance for Inpatient Physician Fee In-Network Providers. No Coverage for Inpatient Physician Fee Out-of-Network Providers.
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply for preventive services. $60/visit, deductible does not apply for Postpartum In-Network Providers. In-Network preventative prenatal and postpartum services are covered at 100%. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). *Coverage includes fertility preservation services, see Fertility Preservation section.
	Childbirth/delivery professional services	40% coinsurance	Not covered	
	Childbirth/delivery facility services	40% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	40% coinsurance	Not covered	100 visits/benefit period for Home Health and Private Duty Nursing combined for In-Network Providers.
	Rehabilitation services	$60/day, deductible does not apply	Not covered	*See Therapy Services section.
	Habilitation services	$60/day, deductible does not apply	Not covered	
	Skilled nursing care	40% coinsurance	Not covered	100 days/benefit period for skilled nursing services for In-Network Providers.
	Durable medical equipment	40% coinsurance	Not covered	*See Durable Medical Equipment section.
	Hospice services	No charge	Not covered	--------none--------
If your child needs dental or eye care	Children's eye exam	No charge, deductible does not apply	Not covered	*See Vision Services section.
	Children's glasses	No charge, deductible does not apply	Not covered	

* For more information about limitations and exceptions, see the plan or policy document at https://eoc.anthem.com/eocdps/ca/0L9ZIND01012027.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Children's dental check-up	No charge	Not covered	*See Dental Services section.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Chiropractic care
- Hearing aids
- Routine eye care (Adult)
- Cosmetic surgery
- Long-term care
- Routine foot care unless medically necessary
- Dental care (Adult)
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

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

- Abortion (including Non-Hyde Abortion Services)
- Infertility treatment
- Acupuncture
- Private-duty nursing 100 visits/benefit period combined with Home Health
- Bariatric surgery

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Managed Health Care, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, (888) 466-2219, https://www.dmhc.ca.gov/, or contact Anthem at the number on the back of your ID card. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

ATTN: Grievances and Appeals, P.O. Box 4310, Woodland Hills, CA 91365-4310

Department of Managed Health Care, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, (888) 466-2219, https://www.dmhc.ca.gov/

Additionally, a consumer assistance program can help you file your appeal. Contact California Consumer Assistance Program, Operated by the California Department of Managed Health Care, 980 9th Street, Suite 500, Sacramento, CA 95814, (888) 466-2219, https://www.dmhc.ca.gov/

* For more information about limitations and exceptions, see the plan or policy document at https://eoc.anthem.com/eocdps/ca/0L9ZIND01012027.

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? Not Applicable.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$5,800**
- **Specialist copayment** **$100**
- **Hospital (facility) coinsurance** **40%**
- **Other copayment** **$50**

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	$5,800
Copayments	$500
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$8,560**

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

- **The plan's overall deductible** **$5,800**
- **Specialist copayment** **$100**
- **Hospital (facility) coinsurance** **40%**
- **Other copayment** **$50**

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	$800
Copayments	$700
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,920**

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

- **The plan's overall deductible** **$5,800**
- **Specialist copayment** **$100**
- **Hospital (facility) coinsurance** **40%**
- **Other copayment** **$50**

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	$2,000
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,200**

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

Get help in your language

Language Assistance Services

Curious to know what all this says? We would be too. Here's the English version: IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help with translations or interpreter services, in a timely manner, please call the telephone number on the back of your ID card. (TTY/TDD:711).

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

Spanish

IMPORTANTE: ¿Puede leer esta carta? Si no es así, podemos pedirle a alguien que lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda oportuna y gratuita con traducciones o servicios de interpretación, llame al número de teléfono que figura en el dorso de su tarjeta de identificación. (TTY/TDD: 711).

Arabic

هام: هل يمكنك قراءة هذه الرسالة؟ إذا لم يكن الأمر كذلك، فيمكننا أن نطلب من شخص ما مساعدتك في قراءتها. قد تتمكن أيضا من الحصول على هذه الرسالة مكتوبة بلغتك. للحصول على مساعدة مجانية في خدمات الترجمة أو الترجمة الفورية، في الوقت المناسب، يرجى الاتصال برقم الهاتف الموجود على ظهر بطاقة ID الهوية الخاصة بك. (TTY/TDD:711).

Armenian

ԿԱՐԵՎՈՐ Է. կարողանո՞ւմ եք կարդալ այս նամակը: Եթե ոչ, կարող ենք օգնել ձեզ կարդալ այն: Դուք կարող եք նաև ստանալ այս նամակը գրավոր՝ ձեր լեզվով: Թարգմանությունների կամ թարգմանչական ծառայությունների անվճար օգնության համար, ժամանակին, խնդրում ենք զանգահարել ձեր ID քարտի հակառակ կողմում նշված հեռախոսահամարով: (TTY/TDD՝ 711):

Chinese

重要提示：您能讀懂這封信嗎？如果不能，
我們可以請人幫您看。您還可以獲得以您的語言寫的此信件。如需及時獲得免費的翻譯或口譯服務協助，請撥打您 ID 卡背面的電話號碼。(TTY/TDD:711)。

Farsi

مهم: می‌توانید این نامه را بخوانید؟ اگر نه، می‌توانیم از کسی بخواهیم که در خواندن آن به شما کمک کند. همچنین ممکن است بتوانید این نامه را به زبان خودتان دریافت کنید. برای دریافت کمک رایگان و به‌موقع در زمینه خدمات ترجمه کتبی یا مترجم شفاهی، لطفاً با شماره تلفن مندرج در پشت کارت ID خود تماس بگیرید.
.(TTY/TDD:711)

Hindi

महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? यदि नहीं, तो हम किसी को इसे पढ़ने में आपकी सहायता करने के लिए रख सकते हैं। आप इस पत्र को अपनी भाषा में भी लिखवा सकते हैं। अनुवाद या दुभाषिया सेवाओं के संबंध में समय पर निःशुल्क सहायता के लिए कृपया अपने पहचान पत्र के पीछे दिए गए टेलीफोन नंबर पर कॉल करें। (TTY/TDD:711)।

Hmong

TSEEM CEEB: Koj puas yeem nyeem tau tsab ntawv no? Yog tias nyeem tsis tau, peb mam kom lwm tus neeg los pab nyeem rau koj.
Koj hais tau kom muab tsab ntawv no sau ua
koj yam lus. Rau kev pab txhais ntawv los sis txhais lus pab dawb, kom raws sij hawm, thov hu tus npawb xov tooj nyob sab nraum qab ntawm koj daim npav ID. (TTY/TDD: 711).

Japanese

重要：この手紙は読めますか？そうでない場合は、誰かに読んでもらうのを手伝ってもらうこともできます。このお知らせは、貴方の言語で受け取ることも可能です。翻訳や通訳サービスの無料サポートをご希望の場合は、ID カードの裏面に記載されている電話番号までお電話ください。(TTY/TDD:711)。

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Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Khmer

សំខាន់៖ តើអ្នកអាចអានសំបុត្រនេះបានទេ? បើអត់ទេ
យើងអាចមានអ្នកជួយអ្នកឱ្យអានវា
បាន។ អ្នកក៏ប្រហែលជាអាចឱ្យសំបុត្រនេះសរសេរ
ជាភាសារបស់អ្នកបានផងដែរ។ ដើម្បីទទួលបាន
ជំនួយដោយឥតគិតថ្លៃជាមួយនឹងការបកប្រែ
ឬសេវាអ្នកបកប្រែផ្ទាល់មាត់ទាន់ពេលវេលា
សូមទូរសព្ទទៅលេខនៅខាងក្រោយកាត ID
របស់អ្នក។ (TTY/TDD:711)។

Korean

중요: 이 서신을 읽으실 수 있습니까? 그렇지 않다면 서신을 읽을 수 있게 도움을 드릴 수 있습니다. 원하시는 언어로 이 서신을 받으실 수도 있습니다. 번역이나 통역 서비스를 무료로 이용하시려면 적시에 ID 카드 뒷면에 있는 전화 번호로 전화해 주십시오. (TTY/TDD: 711).

Punjabi

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵੀ ਲਿਖਵਾ ਸਕਦੇ ਹੋ। ਅਨੁਵਾਦ ਜਾਂ ਦੁਭਾਸ਼ੀਏ ਸੇਵਾਵਾਂ ਵਿੱਚ ਮੁਫ਼ਤ ਮਦਦ ਲਈ, ਸਮੇਂ ਸਿਰ, ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਟੈਲੀਫੋਨ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD:711).

Russian

ВАЖНАЯ ИНФОРМАЦИЯ: Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Чтобы своевременно получить бесплатные услуги письменного или устного перевода, позвоните по номеру телефона, указанному на оборотной стороне вашей идентификационной карты участника. (TTY/TDD: 711).

Tagalog

MAHALAGA: Nababasa mo ba ang sulat na ito? Kung hindi, maaari kaming kumuha ng taong tutulong sa iyo na basahin ito. Maaari mo ring ipasulat ang sulat na ito sa iyong wika. Para sa libreng tulong sa mga pagsasalin o serbisyo ng interpreter, sa isang napapanahong paraan, mangyaring tawagan ang numero ng telepono sa likod ng iyong ID card. (TTY/TDD:711).

Thai

ข้อสำคัญ: คุณสามารถอ่านจดหมายฉบับนี้ได้หรือไม่ ถ้าไม่ เราสามารถหาคนช่วยอ่านให้กับคุณได้ นอกจากนี้คุณยังสามารถขอให้เขียนจดหมายให้ได้ ในภาษาของคุณเอง ขอรับบริการแปลหรือล่ามที่ รวดเร็วได้ฟรี กรุณาติดต่อหมายเลขโทรศัพท์ที่ ด้านหลังของบัตรประจำตัวของคุณ (TTY/TDD:711).

Vietnamese

QUAN TRỌNG: Quý vị có thể đọc lá thư này không? Nếu không, chúng tôi có thể nhờ ai đó giúp quý vị đọc thư. Quý vị cũng có thể yêu cầu viết lá thư này bằng ngôn ngữ của mình. Để được trợ giúp miễn phí về dịch vụ biên dịch hoặc thông dịch một cách kịp thời, vui lòng gọi số điện thoại ở mặt sau thẻ ID của quý vị. (TTY/TDD: 711).

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