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?	**$200** per individual / **$500** per family Does not apply to preventive 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. Preventive care and primary care 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?	Yes, prescription drug deductible: **$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 deductible amount before this plan begins to pay for these services.
What is the out–of–pocket limit for this plan?	For network providers: **$1,000** individual / **$3,000** family for medical, and **$2,500** individual/ **$3,500** family for prescription drugs.	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 PPO 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) $20 / visit thereafter	Billed charges exceeding out-of-network fee schedule.	None
	Specialist visit	$20 / visit	Billed charges exceeding out-of-network fee schedule.	None
	Preventive care/screening /immunization	No Charge	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 **More information about prescription drug coverage is available at www.navitus.com**	Generic drugs	Retail 30-Days: Costco: $0/Rx Other: $10/Rx 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.
	Brand drugs	Deductible (combined Brand & Specialty): $200 per individual $500 per family Retail 30-Days: Costco: $35/Rx Other: $35/Rx 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

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 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: Arthroscopy: $4,500/procedure Cataract Surgery: $2,000/procedure Colonoscopy: $1,500/procedure Upper GI Endoscopy w/Biopsy: $1,250/procedure Upper GI Endoscopy w/o Biopsy: $1,000/procedure Coverage is limited to **$350**/admit 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 +20% coinsurance	$100 / visit +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 +20% coinsurance	$100 / trip +20% coinsurance	None
	Urgent care	$20 / visit	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 fee	20% coinsurance	Billed charges exceeding out-of-network fee schedule.	None

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 have mental health, behavioral health, or substance abuse needs	Outpatient services	Office Visit: $20 / visit 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	$20 / visit	Billed charges exceeding out-of-network fee schedule.	Cost sharing does not apply for preventative services. Depending on 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.

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 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 is limited to a combined total of 100 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).
	Hospice service	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
- Dental care (Adult/Child)
- Infertility treatment
- Long-term care
- Routine foot care
- Private -duty nursing
- Routine eye care (Adult/Child)
- Services not deemed medically necessary
- 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: [insert State, HHS, DOL, and/or other applicable agency contact information]. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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

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**.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet 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'éjíigo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíiłkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilnį́. 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 hodiilnį́.

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.

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	$200
Specialist copayment	$20
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$200
Copayments	$300
Coinsurance	$500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,060**

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

The plan's overall deductible	$200
Specialist copayment	$20
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$400
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$70
The total Joe would pay is	**$1,670**

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

The plan's overall deductible	$200
Specialist copayment	$20
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$200
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$700**

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row on page 1.

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