



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at <https://eoc.anthem.com/eocdps/ca/aso> or by calling 1-866-207-9878.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	For PPO Providers \$500 Member/ \$1,000 Family For Non-PPO Providers \$500 Member/ \$1,000 Family Does not apply to PPO Preventive Care, Primary Care Visit and Specialist Visit. PPO Provider and Non-PPO Provider deductibles are combined.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	Yes. \$250 /Admission for Non-Anthem Blue Cross PPO Hospital or Residential Treatment Center; waived for Emergency admission. \$250 /Admission for Non-Anthem Blue Cross PPO Hospital or Residential Treatment Center if utilization review not obtained; waived for Emergency admission. \$100 /Visit for Emergency Room Services, waived if admitted directly from ER.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. For PPO Providers \$3,000 Member/ \$6,000 Family For Non-PPO Providers \$10,000 Member/ \$20,000 Family PPO Provider and Non-PPO Provider out-of-pocket are separate and do not count towards each other.	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Prescription Drugs cost share, Premiums, Balance-billed charges and Health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.

Questions: Call 1-866-207-9878 or visit us at www.anthem.com/ca.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary

at www.ccjio.cms.gov or call 1-866-207-9878 to request a copy.

Important Questions	Answers	Why this Matters:
Does this plan use a <u>network of providers</u> ?	Yes. See www.anthem.com/ca or call 1-866-207-9878 for a list of PPO Providers.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about excluded services .



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use PPO **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35 Copay/Visit	40% Coinsurance	-----none-----
	Specialist visit	\$35 Copay/Visit	40% Coinsurance	-----none-----

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
	Other practitioner office visit	Chiropractor \$25 Copay/Visit Acupuncturist 20% Coinsurance	Chiropractor 40% Coinsurance Acupuncturist 40% Coinsurance	Chiropractor Coverage is limited to 12 visits per benefit period. Additional visits may be authorized. Services from In-Network and Non-Network providers count towards your benefit period limit. Acupuncturist Coverage is limited to 20 visits for In-Network and Non-Network providers/per benefit period.
	Preventive care/screening/immunization	No Cost Share	40% Coinsurance	-----none-----
If you have a test	Diagnostic test (x-ray, blood work)	Lab - Office 0% Coinsurance X-Ray - Office 0% Coinsurance	Lab - Office 40% Coinsurance X-Ray - Office 40% Coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	40% Coinsurance	Subject to utilization review. Costs may vary by site of service. You should refer to your formal contract of coverage for details.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available	Tier1 - Typically Generic	Not Covered	Not Covered	Carved out to another vendor.
	Tier2 - Typically Preferred / Brand	Not Covered	Not Covered	
	Tier3 - Typically Non-Preferred / Specialty Drugs	Not Covered	Not Covered	
	Tier4 - Typically Specialty Drugs	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$125 Copay/Surgery plus 20% Coinsurance	40% Coinsurance	Coverage is limited to \$350 per Day for Non-PPO Providers.
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	-----none-----

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	20% Coinsurance	20% Coinsurance	Additional deductible of \$100 applies, waived if admitted in patient. This is for the hospital/facility charge only. The ER physician charge may be separate.
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	-----none-----
	Urgent care	\$35 Copay/Visit	40% Coinsurance	Costs may vary by site of service. You should refer to your formal contract of coverage for details.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 /Admission plus 20% Coinsurance	40% Coinsurance	\$250 /admission deductible applies for Non-Anthem Blue Cross PPO hospitals or residential treatment centers; waived for emergency admissions. Failure to obtain utilization review will result in an additional \$250 deductible for Non-Anthem Blue Cross PPO hospitals or residential treatment centers; waived for emergency admissions. Subject to utilization review for inpatient services; waived for emergency admissions. Coverage is limited to \$600 per Day for Non-PPO Providers.
	Physician/surgeon fee	20% Coinsurance	40% Coinsurance	-----none-----

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit \$35 Copay/Visit Mental/Behavioral Health Facility Visit - Facility Charges 20% Coinsurance	Mental/Behavioral Health Office Visit 40% Coinsurance Mental/Behavioral Health Facility Visit - Facility Charges 40% Coinsurance	-----none-----
	Mental/Behavioral health inpatient services	20% Coinsurance	40% Coinsurance	This is for facility professional services only. Please refer to your hospital stay for facility fee.
	Substance use disorder outpatient services	Substance Abuse Office Visit \$35 Copay/Visit Substance Abuse Facility Visit - Facility Charges 20% Coinsurance	Substance Abuse Office Visit 40% Coinsurance Substance Abuse Facility Visit - Facility Charges 40% Coinsurance	-----none-----
	Substance use disorder inpatient services	20% Coinsurance	40% Coinsurance	This is for facility professional services only. Please refer to your hospital stay for facility fee.
If you are pregnant	Prenatal and postnatal care	20% Coinsurance	40% Coinsurance	-----none-----
	Delivery and all inpatient services	\$250 /Admission plus 20% Coinsurance	40% Coinsurance	\$250 /admission deductible applies for Non-Anthem Blue Cross PPO hospitals; waived for emergency admissions. Failure to obtain utilization review will result in an additional \$250 deductible for Non-Anthem Blue Cross PPO hospitals; waived for emergency admissions. Subject to utilization review for inpatient services; waived for emergency admissions. Coverage is limited to \$600 per Day for Non-PPO Providers.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	20% Coinsurance	Subject to utilization review. Coverage is limited to a total of 100 visits, In-Network Provider and Non-Network Provider combined per benefit period (one visit by a home health aide equals four hours or less; not covered while member receives hospice care). Services from In-Network Provider and Non-Network Provider count towards your limit.
	Rehabilitation services	\$25 Copay/Visit Speech Therapy: \$35 Copay/Visit	40% Coinsurance	-----none-----
	Habilitation services	\$25 Copay/Visit	40% Coinsurance	-----none-----
	Skilled nursing care	20% Coinsurance	20% Coinsurance	Subject to utilization review. Coverage is limited to a combined total of 100 days per benefit period for services received from In-Network & Non-Network Providers.
	Durable medical equipment	20% Coinsurance	20% Coinsurance	-----none-----
	Hospice service	0% Coinsurance	0% Coinsurance	Subject to utilization review.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	-----none-----
	Glasses	Not Covered	Not Covered	-----none-----
	Dental check-up	Not Covered	Not Covered	-----none-----

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (Unless you have been diagnosed with diabetes.)
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery (For morbid obesity, consult your formal contract of coverage.)
- Chiropractic care
- Hearing aids (Coverage is limited to one hearing aid per ear every three years.)
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-207-9878. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

Anthem Blue Cross
ATTN: Appeals or Grievance
P.O. Box 4310
Woodland Hills, CA 91367

Department of Managed Health Care
California Help Center
980 9th Street, Suite 500
Sacramento, CA 95814-2725
1-888-HMO-2219

Or Contact:

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

A consumer assistance program can help you file your appeal. Contact:
California Department of Managed Health Care Help Center
980 9th Street, Suite 500
Sacramento, CA 95814
(888) 466-2219
<http://www.healthhelp.ca.gov>
helpline@dmhc.ca.gov

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'i, shikáa adoolwol íinízínigo t'áá diné k'éjíggo, t'áá shoodí ba na'alníhí ya sidáhí bich'í naabííílkíid. Eí doo biigha daago ni ba'nija'go ho'aalagíí bich'í hodiilní. Hai'daq íini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béesh bee hane'í wólta' bí'ki si'niilígíí 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 page.*—————

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays: \$6,250
- Patient pays: \$1,290

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$500
Copays	\$250
Coinsurance	\$370
Limits or exclusions	\$170
Total	\$1,290

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays: \$1,470
- Patient pays: \$3,930

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$500
Copays	\$290
Coinsurance	\$210
Limits or exclusions	\$2,930
Total	\$3,930

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-866-207-9878 or visit us at www.anthem.com/ca.

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