

 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, [www.anthem.com/ca/calpers](http://www.anthem.com/ca/calpers). 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 (855) 839-4524 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0.	There is no overall <a href="#">deductible</a> for this plan.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes.	There is no <a href="#">deductible</a> to meet before the <a href="#">plan</a> pays for services.
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>\$1,500</b> /single or <b>\$3,000</b> /family for In- <a href="#">Network Providers</a> . This <a href="#">plan</a> has a separate Out of Pocket Maximum for <a href="#">Prescription Drugs</a> of <b>\$7,600</b> /individual or <b>\$15,200</b> /family, <b>\$1,000</b> Home delivery for In- <a href="#">Network Providers</a> .	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met. Whichever is met first.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Infertility services, <a href="#">Premiums</a> , <a href="#">Balance-Billing</a> charges and Health Care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes, California Care HMO. See <a href="http://www.anthem.com/ca/calpers">www.anthem.com/ca/calpers</a> or call (855) 839-4524 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an out-of- <a href="#">network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes.	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .



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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$15/visit	Not covered	-----none-----
	<a href="#">Specialist</a> visit	\$15/visit	Not covered	-----none-----
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	You may have to pay a copay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	-----none-----
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.optumrx.com/calpers">http://www.optumrx.com/calpers</a>	Tier 1 - Typically Generic	\$5/prescription (retail) and \$10/prescription (home delivery)	Not covered	Most home delivery is 90-day supply. *See Prescription Drug section of the <a href="#">plan</a> or policy document (e.g. evidence of coverage or certificate).
	Tier 2 - Typically <a href="#">Preferred Brand</a>	\$20/prescription (retail) and \$40/prescription (home delivery)	Not covered	
	Tier 3 - Typically Non- <a href="#">Preferred</a> / <a href="#">Specialty Drugs</a>	\$50/prescription (retail) and \$100/prescription (home delivery)	Not covered	
	Tier 4 - Typically <a href="#">Specialty</a> (brand and generic)	<a href="#">Specialty</a> follows the tier structure above.	Not covered	
If you have outpatient surgery	Facility fee (e.g., hospital, ambulatory surgery center)	No charge	Not covered	-----none-----
	Physician/surgeon fees	No charge	Not covered	-----none-----
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$50/visit	Covered as In- <a href="#">Network</a>	If admitted inpatient, ER copay is waived.
	<a href="#">Emergency medical transportation</a>	No charge	Covered as In- <a href="#">Network</a>	-----none-----
	<a href="#">Urgent care</a>	\$15/visit	Covered as In- <a href="#">Network</a>	Out-of- <a href="#">Network</a> only covered when out of area. For in area, contact your PCP or medical group.

\* For more information about limitations and exceptions, see [plan](#) or policy document at [www.anthem.com/ca/calpers](http://www.anthem.com/ca/calpers).

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 have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	-----none-----
	Physician/surgeon fees	No charge	Not covered	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit \$15/visit Other Outpatient No charge	Office Visit Not covered Other Outpatient Not covered	Office Visit -----none----- Other Outpatient Precertification may be required.
	Inpatient services	No charge	Not covered	No charge for Inpatient Physician Fee In- <a href="#">Network Providers</a> . No coverage for Inpatient Physician Fee Out-of- <a href="#">Network Providers</a> . Precertification is required.
If you are pregnant	Office visits	No charge	Not covered	<a href="#">Cost sharing</a> does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	No charge	Not covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	Not covered	-----none-----
	<a href="#">Rehabilitation services</a>	\$15/visit	Not covered	*See Therapy Services section
	<a href="#">Habilitation services</a>	\$15/visit	Not covered	
	<a href="#">Skilled nursing care</a>	No charge	Not covered	100 days limit/benefit period for In- <a href="#">Network Providers</a> .
	<a href="#">Durable medical equipment</a>	No charge	Not covered	-----none-----
	<a href="#">Hospice services</a>	No charge	Not covered	-----none-----
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	*See Vision Services section
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	*See Dental Services section

\* For more information about limitations and exceptions, see [plan](#) or policy document at [www.anthem.com/ca/calpers](http://www.anthem.com/ca/calpers).

## 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
- Glasses for a child
- Non-emergency care when traveling outside the U.S.
- Weight loss programs
- Dental care (adult)
- Infertility treatment
- Private-duty nursing
- Dental Check-up
- Long-term care
- Routine foot care unless you have been diagnosed with diabetes.

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

- Acupuncture 20 visits/benefit period combined with Chiropractic care.
- Hearing aids 1 per ear/every 36 months.
- Bariatric surgery (For morbid obesity. Consult your formal contract of coverage).
- Routine eye care (adult) one visit/benefit period.
- Chiropractic care 20 visits/benefit period combined with Acupuncture.

**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 Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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](http://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:

ATTN: Anthem Blue Cross, Grievance and Appeal Management, P.O. Box 4310, Woodland Hills, CA 91365

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

California Department of Managed Health Care Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814, (888) 466-2219, [www.dmhc.ca.gov](http://www.dmhc.ca.gov), [helpline@dmhc.ca.gov](mailto:helpline@dmhc.ca.gov)

**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](#).

\* For more information about limitations and exceptions, see [plan](#) or policy document at [www.anthem.com/ca/calpers](http://www.anthem.com/ca/calpers).



## Language Access Services:

(TTY/TDD: 711)

**Albanian (Shqip):** Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (855) 839-4524

**Amharic (አማርኛ):-** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 839-4524 ይደውሉ።

**Arabic (العربية):** إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (855) 839-4524

**Armenian (հայերեն).** Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (855) 839-4524:

**Bassa (Bàsɔ̀ Wùdù):** M̄ dyi dyi-diè-dɛ̀ bɛ̀ bédé b́á céè-dɛ̀ nià ke dyí ní, ɔ̀ m̀ò ni dyí-bédèin-dɛ̀ bɛ̀ m̀ ké gbo-kpá-kpá kè b̄́ kp̄́ dɛ̀ m̀ bídí-wùdùùn b́ó pídyi. B́é m̀ ké wuɖu-zìin-nyò d̀ò gbo wùdù ke, d́á (855) 839-4524.

**Bengali (বাংলা):** যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (855) 839-4524 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (855) 839-4524 သို့ ခေါ်ဆိုပါ။

**Chinese (中文):** 如果您对本文件有任何疑问，您有权使用您的语言免费获得协助和资讯。如需与译员通话，请致电 (855) 839-4524。

**Dinka (Dinka):** Na nɔŋ thiëc në ke de yā thorë, ke yin nɔŋ loŋ bē yi kuony ku wɛr alëu bē gɛɛr yic yin ne thoŋ du ke cin wëu tāäuë ke piny. Te kør yin ba jam wënë ran ye thok geryic, ke yin cöl (855) 839-4524.

**Dutch (Nederlands):** Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (855) 839-4524.

**Farsi (فارسي):** در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (855) 839-4524 تماس بگیرید.

**French (Français):** Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (855) 839-4524.

## Language Access Services:

**German (Deutsch):** Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (855) 839-4524.

**Greek (Ελληνικά)** Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (855) 839-4524.

**Gujarati (ગુજરાતી):** જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (855) 839-4524.

**Haitian Creole (Kreyòl Ayisyen):** Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (855) 839-4524.

**Hindi (हिंदी):** अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (855) 839-4524 ।

**Hmong (White Hmong):** Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (855) 839-4524.

**Igbo (Igbo):** Ọ bụr ụ na ị nwere ajuju ọ bụla gbasara akwukwo a, ị nwere ikike inweta enyemaka na ozi n'asusu gi na akwughị ugwo ọ bụla. Ka gi na okowa okwu kwuo okwu, kpoo (855) 839-4524.

**Ilokano (Ilokano):** Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (855) 839-4524.

**Indonesian (Bahasa Indonesia):** Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (855) 839-4524.

**Italian (Italiano):** In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (855) 839-4524

**Japanese (日本語):** この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(855) 839-4524 にお電話ください。

## Language Access Services:

**Khmer (ខ្មែរ):** បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។  
ដើម្បីជ្រកជាមួយអ្នកបកប្រែ សូមហៅ (855) 839-4524 ។

**Kirundi (Kirundi):** Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuze, akura (855) 839-4524.

**Korean (한국어):** 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (855) 839-4524 로 문의하십시오.

**Lao (ພາສາລາວ):** ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.  
ເພື່ອໂອ້ນລັບກ່ຽວກັບພາສາ, ໃຫ້ໃບທາ (855) 839-4524.

**Navajo (Diné):** Díí naaltsoos biká'ígíí lahgo bina'idíilkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bááh ilínígóó.  
Ata' halne'ígíí la' bich'í' hadeesdzih nínízingo kojí' hodiílnih (855) 839-4524.

**Nepali (नेपाली):** यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ।  
दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (855) 839-4524

**Oromo (Oromifaa):** Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (855) 839-4524 bilbilla.

**Pennsylvania Dutch (Deutsch):** Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Hilfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff (855) 839-4524 aa.

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