Anthem Blue Cross of California
Anthem Gold PPO 500/20%/6500

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2017 – 12/31/2017
Coverage for: Individual + Family | **Plan Type:** PPO

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:/eocdps/2EXESMG01012017 or by calling (855) 383-7248.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** person / **$1,500** family for In-Network Providers. Does not apply to Preventive Care, Primary Care visit, and Specialist visit. **$1,000** person / **$2,000** family for Out-of-Network Providers.	You must pay all costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes; **$250** person / **$500** family for In-Network Providers Tier 2, Tier 3 and Tier 4 Prescription Drugs. 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.
Is there an out–of–pocket limit on my expenses?	Yes; **$6,500** person / **$13,000** family for In-Network Providers. **$13,000** person / **$26,000** family for Out-of-Network Providers.	The **out-of-pocket limit** 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 out–of–pocket limit?	Premiums, Balance-Billed 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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes, Prudent Buyer PPO. For a list of In-Network	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

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Important Questions	Answers	Why this Matters:
	providers, see www.anthem.com/ca or call **(855) 383-7248**. Dental and Vision benefits may access a different network of providers.	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 3 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No; you do not 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 9. 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 **In-Network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met	--------none--------
	Specialist visit	$60 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met	--------none--------
	Other practitioner office visit	50% coinsurance medical deductible does not apply	Not covered	Coverage for In-Network Providers is limited to 20 visits per benefit period.
	Preventive care/screening/immunization	No charge	50% coinsurance after medical deductible is met	--------none--------
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office 20% coinsurance after medical deductible is met X-Ray – Office 20% coinsurance after medical deductible is met	Lab – Office 50% coinsurance after medical deductible is met X-Ray – Office 50% coinsurance after medical deductible is met	Lab – Office --------none-------- X-Ray – Office --------none--------
	Imaging (CT/PET scans, MRIs)	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met	Coverage for Non-Network Providers is limited to $800 maximum benefit per procedure.
If you need drugs to treat your illness or	Tier 1a - Typically Lower Cost Generic	$5 copay per prescription pharmacy deductible does not	Not covered	Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Non-Network Provider	Limitations & Exceptions
condition More information about **prescription drug coverage** is available at http://www.anthem.com/pharmacyinformation/ Anthem Select Drug List		apply (retail only) and $13 copay per prescription pharmacy deductible does not apply (home delivery only)		
	Tier 1b - Typically Generic	$20 copay per prescription pharmacy deductible does not apply (retail only) and $50 copay per prescription pharmacy deductible does not apply (home delivery only)	Not covered	Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).
	Tier 2 - Typically Preferred Brand & Non-Preferred Generics	$40 copay per prescription after pharmacy deductible is met (retail only) and $120 copay per prescription after pharmacy deductible is met (home delivery only)	Not covered	Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).
	Tier 3 - Typically Non-Preferred Brand	$80 copay per prescription after pharmacy deductible is met (retail only) and $240 copay per prescription after pharmacy deductible is met (home delivery only)	Not covered	Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).
	Tier 4 - Typically Specialty (brand and generic)	30% coinsurance up to a $250 maximum after pharmacy deductible is met (retail and home	Not covered	Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program).

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Non-Network Provider	Limitations & Exceptions
		delivery)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met	Coverage for Non-Network Providers is limited to $380 maximum benefit per admission.
	Physician/surgeon fees	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met	--------none--------
If you need immediate medical attention	Emergency room services	Emergency Room Physician Fee 20% coinsurance after medical deductible is met Emergency Room Facility Fee $250 copay per visit and then 20% coinsurance after medical deductible is met	Emergency Room Physician Fee Covered as In-Network Emergency Room Facility Fee Covered as In-Network	Emergency Room Physician Fee --------none-------- Emergency Room Facility Fee Copay waived if admitted.
	Emergency medical transportation	20% coinsurance after medical deductible is met	Covered as In-Network	--------none--------
	Urgent care	$60 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met	Coverage for Non-Network Providers is limited to $650 maximum benefit per day. Coverage for Inpatient rehabilitation and skilled nursing services combined In-Network Providers and Non-Network Providers combined is limited to 100 days per benefit period.
	Physician/surgeon fee	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met	--------none--------
If you have mental health,	Mental/Behavioral health outpatient services	Office Visit $30 copay per visit	Office Visit 50% coinsurance after	Office Visit --------none--------

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Non-Network Provider	Limitations & Exceptions
behavioral health, or substance abuse needs		medical deductible does not apply Other Outpatient 20% coinsurance after medical deductible is met	medical deductible is met Other Outpatient 50% coinsurance after medical deductible is met	Other Outpatient --------none--------
	Mental/Behavioral health inpatient services	Inpatient Facility Fee 20% coinsurance after medical deductible is met Inpatient Physician Fees 20% coinsurance after medical deductible is met	Inpatient Facility Fee 50% coinsurance after medical deductible is met Inpatient Physician Fees 50% coinsurance after medical deductible is met	Inpatient Facility Fee Coverage for Non-Network Providers is limited to $650 maximum benefit per day. Inpatient Physician Fees --------none--------
	Substance use disorder outpatient services	Office Visit $30 copay per visit medical deductible does not apply Other Outpatient 20% coinsurance after medical deductible is met	Office Visit 50% coinsurance after medical deductible is met Other Outpatient 50% coinsurance after medical deductible is met	Office Visit --------none-------- Other Outpatient --------none--------
	Substance use disorder inpatient services	Inpatient Facility Fee 20% coinsurance after medical deductible is met Inpatient Physician Fees 20% coinsurance after medical deductible is met	Inpatient Facility Fee 50% coinsurance after medical deductible is met Inpatient Physician Fees 50% coinsurance after medical deductible is met	Inpatient Facility Fee Coverage for Non-Network Providers is limited to $650 maximum benefit per day. Inpatient Physician Fees --------none--------
If you are pregnant	Prenatal and postnatal care	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met	In-Network preventative prenatal and postnatal services are covered at 100%
	Delivery and all inpatient services	Inpatient Facility Fee 20% coinsurance after	Inpatient Facility Fee 50% coinsurance after	Inpatient Facility Fee Coverage for Non-Network Providers

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Non-Network Provider	Limitations & Exceptions
		medical deductible is met Inpatient Physician Fees 20% coinsurance after medical deductible is met	medical deductible is met Inpatient Physician Fees 50% coinsurance after medical deductible is met	is limited to $650 maximum benefit per day. Applies to inpatient facility. Other cost shares may apply depending on services provided. Inpatient Physician Fees --------none--------
If you need help recovering or have other special health needs	Home health care	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met	Coverage for In-Network Providers and Non-Network Providers combined is limited to 100 visits per benefit period. Coverage for Non-Network Providers is limited to $75 maximum benefit per visit.
	Rehabilitation services	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met	--------none--------
	Habilitation services	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met	--------none--------
	Skilled nursing care	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met	Coverage for Non-Network Providers is limited to $150 maximum benefit per day. Coverage for Inpatient rehabilitation and skilled nursing services combined In-Network Providers and Non-Network Providers combined is limited to 100 days per benefit period.
	Durable medical equipment	50% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met	--------none--------
	Hospice service	0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met	--------none--------
If your child needs dental or eye care	Eye exam	No charge	No charge	Coverage for In-Network Providers and Non-Network Providers combined is limited to 1 exam per benefit period. Costs may vary by site

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Non-Network Provider	Limitations & Exceptions
				of service. You should refer to your formal contract of coverage for details.
	Glasses	No charge	No charge	Coverage for In-Network Providers and Non-Network Providers combined is limited to 1 unit per benefit period.
	Dental check-up	No charge	No charge	Coverage for In-Network Providers and Non-Network Providers combined is limited to 1 visit per 6 months.

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)
- Hearing aids
- Infertility treatment
- Long-term care
- Routine foot care
- 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
- Chiropractic care Coverage is limited to 20 visits per benefit period.
- Most coverage provided outside the United States. See www.sbc.com/bluecardworldwide
- Private-duty nursing Coverage is limited to 100 visits per benefit period.
- Routine eye care (Adult) Coverage is limited to 1 exam per benefit period.

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 (855) 383-7248. 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:

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

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

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

California Consumer Assistance Program
Operated by the California Department of Managed Health Care
980 9th St, Suite #500
Sacramento, CA 95814
(888) 466-2219
http://www.HealthHelp.ca.gov

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

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。

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoolwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíiłkiid. 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.

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.

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.

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 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** $5,710
- **Patient pays** $1,830

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	$30
Coinsurance	$1,300
Limits or exclusions	$0
Total	$1,830

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,300
- **Patient pays** $2,100

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	$1,400
Coinsurance	$0
Limits or exclusions	$200
Total	$2,100

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**, **co payments**, 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.

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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) 383-7248

Amharic (አማርኛ):- ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 383-7248 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) 383-7248.

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) 383-7248:

Bassa (Bǎsɔ́ɔ̀ Wùdù): Mˋ dyi dyi-diè-dɛ̀ bě bédé bá céè-dɛ̀ nià kɛ dyí ní, ɔ mɔ̀ nì dyí-bɛ̀dɛ̀ìn-dɛ̀ bɛ́ m̀ ké gbo-kpá-kpá kè bɔ̌ kpɔ̃ dé m̀ bídí-wùdùǔn bó pídyi. Bé m̀ ké wudu-zììn-nyɔ̀ dò gbo wùdù kɛ, dá (855) 383-7248.

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) 383-7248 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် (855) 383-7248 သို့ ခေါ်ဆိုပါ။

Chinese (中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (855) 383-7248。

Dinka (Dinka): Na nɔŋ thiëëc në ke de yä thorë, ke yin nɔŋ loŋ bë yi kuony ku wɛr alëu bë gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kɔr yin ba jam wënë ran ye thok geryic, ke yin cɔl (855) 383-7248.

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) 383-7248.

Farsi (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (855) 383-7248 تماس بگیرید.

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Language Access Services:

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