



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. 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 (855) 839-4524 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0.	There is no overall deductible for this plan.
Are there services covered before you meet your deductible ?	Yes.	There is no deductible to meet before the plan pays for services.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$1,500/single or \$3,000/family for In-Network Providers. This plan has a separate Out of Pocket Maximum for Prescription Drugs of \$8,650/individual or \$17,300/family, \$1,000 Home delivery 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. Whichever is met first.
What is not included in the out-of-pocket limit ?	Infertility 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, Select HMO. See www.anthem.com/ca/calpers or call (855) 839-4524 for a list of network providers .	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	\$15/visit	Not covered	-----none-----
	<u>Specialist</u> visit	\$15/visit	Not covered	-----none-----
	<u>Preventive care/screening/</u> immunization	No charge	Not covered	You may have to pay a copay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (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 <u>prescription drug coverage</u> is available at http://www.caremark.com/calpers	Tier 1	\$5/30-day supply \$10/90-day supply	Not covered	Your Prescription Drug Coverage is covered by CVS Caremark. For more information, please call 833-291-3649. A 90-day supply can be obtained via home delivery or at an in-network retail pharmacy.
	Tier 2	\$20/30-day supply \$40/90-day supply	Not covered	
	Tier 3	\$50/30-day supply \$100/90-day supply	Not covered	Certain Specialty Medications are available only through CVS Caremark Specialty Pharmacy and are limited up to a 30-day supply.
	<u>Specialty Pharmacy</u>	<u>Specialty</u> follows the tier structure above.	Not covered	
	Facility fee (e.g., hospital, ambulatory surgery center)	No charge	Not covered	-----none-----
If you have outpatient surgery	Physician/surgeon fees	No charge	Not covered	-----none-----
	<u>Emergency room care</u>	\$50/visit	Covered as In- <u>Network</u>	If admitted inpatient, ER copay is waived.
If you need immediate medical attention	<u>Emergency medical transportation</u>	No charge	Covered as In- <u>Network</u>	-----none-----
	<u>Urgent care</u>	\$15/visit	Covered as In- <u>Network</u>	Out-of- <u>network</u> 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.

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- Network Providers . No coverage for Inpatient Physician Fee Out-of- Network Providers . Precertification is required
If you are pregnant	Office visits	No charge	Not covered	Cost sharing 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	Home health care	No charge	Not covered	-----none-----
	Rehabilitation services	\$15/visit	Not covered	*See Therapy Services section
	Habilitation services	\$15/visit	Not covered	
	Skilled nursing care	No charge	Not covered	100 days limit/benefit period for In- Network Providers .
	Durable medical equipment	No charge	Not covered	-----none-----
	Hospice services	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.

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

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.	• Bariatric surgery	• Chiropractic care 20 visits/benefit period combined with Acupuncture.
• Hearing aids 1 per ear/every 36 months.	• Routine eye care (adult) one visit/benefit period.	

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. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](http://HealthInsuranceMarketplace). 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:

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

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), 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, 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.

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)

<input type="checkbox"/> The plan's overall deductible	\$0
<input type="checkbox"/> Specialist copayment	\$0
<input type="checkbox"/> Hospital (facility) coinsurance	0%
<input type="checkbox"/> Other coinsurance	0%

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
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In this example, Peg would pay:

<u>Cost Sharing</u>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$60

Managing Joe's Type 2 Diabetes

(a year of routine in network care of a well controlled condition)

<input type="checkbox"/> The plan's overall deductible	\$0
<input type="checkbox"/> Specialist copayment	\$15
<input type="checkbox"/> Hospital (facility) coinsurance	0%
<input type="checkbox"/> Other coinsurance	0%

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
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In this example, Joe would pay:

<u>Cost Sharing</u>	
Deductibles	\$0
Copayments	\$180
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$210

Mia's Simple Fracture

(in network emergency room visit and follow up care)

<input type="checkbox"/> The plan's overall deductible	\$0
<input type="checkbox"/> Emergency Room copayment	\$50
<input type="checkbox"/> Hospital (facility) coinsurance	0%
<input type="checkbox"/> Other coinsurance	0%

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
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In this example, Mia would pay:

<u>Cost Sharing</u>	
Deductibles	\$0
Copayments	\$150
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$150

* For more information about limitations and exceptions, see [plan](#) or policy document at 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): ከለሁ ሰነድ ማንኛውም ጥያቄ ካለማት በፈለም ቁንቁ እርዳታ እና ይህን መረጃ በነዚ የሚገኘት መብት ካለማት:: አስተርጓሚ ለማናገድ (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 (Bаssá Wùndù): M dyí dyi-diè-dè bé bédé bá céè-dè nià ke dyí ní, o mò nì dyí-bédèin-dè bé m kék gbo-kpá-kpá kék bék kpék dé m bídí-wùndùn bó pídyi. Bé m kék wuqu-zììn-nyò dò gbo wùndù ke, dák (855) 839-4524.

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

Burmese (မြန်မာ): ဤတရုပ်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် ပေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကုအညီကို အခြောင်းငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် (855) 839-4524 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) 839-4524。

Dinka (Dinka): Na noŋ thiéec nē ke de yä thorë, ke yin noŋ loŋ bē yi kuony ku wer alëu bē geer yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kör 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 (فارسی): 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 दस्तावेज 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): O bụr ụ na ị nwere ajụụ ọ bụla gbasara akwụkwọ a, ị nwere ikiye ịnweta enyemaka na ozi n'asụṣụ gi na akwụghị ụgwọ ọ bụla. Ka gi na ọkowa okwu kwuo okwu, kpọọ (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): បើមុខមានសំណូរដោះស្រាយទៅការអាសយដ្ឋាន៖ អ្នកមានសិទ្ធិទទួលដំឡូយនិងតំមានជាការបស់អ្នកដោយតាមគេត្រូវ។ ដើម្បីចងកម្មូយអ្នកបានប្រើ ស្ថាបោរ (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 umusemuzi, 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): ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ອງທ່ານໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ແລ້ວ. ເພື່ອໄວ້ວິນກັບວ່າມີເປົ້າສາ, ໃຫ້ໃຫຍ້ (855) 839-4524.

Navajo (Diné): Díí naaltsoos biká’ígíí lahgo bina’idílkidgo ná bohónéedzá dóó bee ahóót’í’ t’áá ni nizaad k’ehjí bee níl hodoonih t’áadoo bájéh ilníg óó. Ata’ halne’ígíí la’ bich’í’ hadeesdzih nímízingo koj’ hodiílnih (855) 839-4524.

Nepali (नेपाली): यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफै 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 wajiiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuuf fi odeeefanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (855) 839-4524 bilbilla.

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