




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, <https://eoc.anthem.com/eocdps/ca/82DNIND01012025>. 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 (833) 913-2233 to request a copy.

| Important Questions | Answers | Why This Matters: |
|--|--|--|
| What is the overall deductible? | \$5,400/person or \$10,800/family for In- <u>Network Providers</u> . | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . |
| Are there services covered before you meet your deductible? | Yes. Primary Care. <u>Specialist Visit</u> . <u>Preventive Care</u> . Dental. Vision. For more information see below. | This plan covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | Yes. \$50/person or \$100/family for <u>Prescription Drugs In-Network Providers</u> . There are no other specific <u>deductibles</u> . | 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. |
| What is the out-of-pocket limit for this plan? | \$8,700/person or \$17,400/family for In- <u>Network Providers</u> . | The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. |
| What is not included in the out-of-pocket limit? | <u>Premiums</u> , <u>balance-billing</u> 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> . |
| Will you pay less if you use a network provider? | Yes. See www.anthem.com/find-care/?alphaprefix=JQL or call (833) 913-2233 for a list of <u>network providers</u> . Costs may vary by site of service and how the <u>provider</u> bills. | This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's network . You will pay the most if you use an <u>Out-of-Network Provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your plan pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>Out-of-Network Provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |

| | | |
|--|------|--|
| Do you need a referral to see a specialist? | Yes. | This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> . |
|--|------|--|

 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 | \$50/visit, <u>deductible</u> does not apply | Not covered | Virtual visits (Telehealth) benefits available. |
| | <u>Specialist</u> visit | \$90/visit, <u>deductible</u> does not apply | Not covered | Virtual visits (Telehealth) benefits available. |
| | <u>Preventive care</u> / <u>screening</u> /immunization | No charge | Not covered | You may have to pay 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) | Lab – Office \$50/day, <u>deductible</u> does not apply X-Ray – Office \$95/day, <u>deductible</u> does not apply | Lab – Office Not covered X-Ray – Office Not covered | -----none----- |
| | Imaging (CT/PET scans, MRIs) | \$325/day, <u>deductible</u> does not apply | Not covered | -----none----- |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.anthem.com/pharmacyinformation/ | Typically Generic (Tier 1) | \$18/prescription, Prescription Drug <u>deductible</u> does not apply (retail) and \$54/prescription, Prescription Drug <u>deductible</u> does not apply (home delivery) | Not covered (retail and home delivery) | Most home delivery is 90-day supply. For more information, refer to “CA Select IND Drug List” at http://www.anthem.com/pharmacyinformation/ *See Prescription Drug section of the <u>plan</u> or policy document (e.g. evidence of coverage or certificate). |
| | Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 2) | \$60/prescription, Prescription Drug <u>deductible</u> applies (retail) and \$180/prescription, Prescription Drug <u>deductible</u> applies (home delivery) | Not covered (retail and home delivery) | |
| | Typically Non-Preferred Brand and Generic drugs (Tier 3) | \$90/prescription, Prescription Drug <u>deductible</u> applies (retail) and \$270/prescription, Prescription Drug <u>deductible</u> applies (home delivery) | Not covered (retail and home delivery) | |

* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/ca/82DNIND01012025>.

| 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) | |
| | Typically Preferred Specialty (brand and generic) (Tier 4) | 20% <u>coinsurance</u> up to \$250/prescription, Prescription Drug <u>deductible</u> applies (retail) and 20% <u>coinsurance</u> up to \$750/prescription, Prescription Drug <u>deductible</u> applies (home delivery) | Not covered (retail and home delivery) | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 30% <u>coinsurance</u> , <u>deductible</u> does not apply | Not covered | -----none----- |
| | Physician/surgeon fees | 30% <u>coinsurance</u> , <u>deductible</u> does not apply | Not covered | -----none----- |
| If you need immediate medical attention | <u>Emergency room care</u> | \$400/visit, <u>deductible</u> does not apply | Covered as In- <u>Network</u> | <u>Copayment</u> waived if admitted. No charge for Emergency Room Physician Fee. |
| | <u>Emergency medical transportation</u> | \$255/trip, <u>deductible</u> does not apply | Covered as In- <u>Network</u> | Non-emergency <u>Out-of-Network</u> water Ambulance Services are limited to \$50,000 per trip, does not apply to ground or air ambulance. |
| | <u>Urgent care</u> | \$50/visit, <u>deductible</u> does not apply | Covered as In- <u>Network</u> | -----none----- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 30% <u>coinsurance</u> | Not covered | -----none----- |
| | Physician/surgeon fees | 30% <u>coinsurance</u> , <u>deductible</u> does not apply | Not covered | -----none----- |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office Visit \$50/visit, <u>deductible</u> does not apply Other Outpatient 30% <u>coinsurance</u> , <u>deductible</u> does not apply, up to a \$50 maximum | Office Visit Not covered Other Outpatient Not covered | Office Visit 988 lifeline/mobile crisis team covered as In- <u>Network</u> . Virtual visits (Telehealth) benefits available. Other Outpatient -----none----- |

* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/ca/82DNIND01012025>.

| 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) | |
| | Inpatient services | 30% <u>coinsurance</u> | Not covered | 30% <u>coinsurance</u> , <u>deductible</u> does not apply for Inpatient Physician Fee <u>In-Network Providers</u> . No Coverage for Inpatient Physician Fee <u>Out-of-Network Providers</u> . |
| If you are pregnant | Office visits | No charge | Not covered | <u>Cost sharing</u> does not apply for <u>preventive services</u> . \$50/visit, <u>deductible</u> does not apply for Postnatal <u>In-Network Providers</u> . <u>In-Network</u> prenatal and postnatal services are covered at 100%. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). *Coverage includes fertility preservation services, see Fertility Preservation section. |
| | Childbirth/delivery professional services | 30% <u>coinsurance</u> , <u>deductible</u> does not apply | Not covered | |
| | Childbirth/delivery facility services | 30% <u>coinsurance</u> | Not covered | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | \$45/visit, <u>deductible</u> does not apply | Not covered | 100 visits/benefit period for Home Health and Private Duty Nursing combined for <u>In-Network Providers</u> . |
| | <u>Rehabilitation services</u> | \$50/day, <u>deductible</u> does not apply | Not covered | *See Therapy Services section. |
| | <u>Habilitation services</u> | \$50/day, <u>deductible</u> does not apply | Not covered | |
| | <u>Skilled nursing care</u> | 30% <u>coinsurance</u> | Not covered | 100 days/benefit period for skilled nursing services for <u>In-Network Providers</u> . |
| | <u>Durable medical equipment</u> | 20% <u>coinsurance</u> , <u>deductible</u> does not apply | Not covered | *See <u>Durable Medical Equipment</u> section. |
| | <u>Hospice services</u> | 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 | No charge | Not covered | |
| | Children's dental check-up | No charge | Not covered | *See Dental Services section. |

* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/ca/82DNIND01012025>.

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.)

- Chiropractic care
- Hearing aids
- Routine eye care (Adult)
- Cosmetic surgery
- Long-term care
- Routine foot care unless medically necessary
- Dental care (Adult)
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

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

- Abortion (including Non-Hyde Abortion Services)
- Infertility treatment
- Acupuncture
- Private-duty nursing 100 visits/benefit period combined with Home Health
- Bariatric surgery

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 Managed Health Care, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, (888) 466-2219, <https://www.dmhca.gov/>, or contact Anthem at the number on the back of your ID card. 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 on how 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: Grievances and Appeals, P.O. Box 4310, Woodland Hills, CA 91365-4310

Department of Managed Health Care, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, (888) 466-2219, <https://www.dmhca.gov/>

Additionally, a consumer assistance program can help you file your appeal. Contact California Consumer Assistance Program, Operated by the California Department of Managed Health Care, 980 9th Street, Suite 500, Sacramento, CA 95814, (888) 466-2219, <https://www.dmhca.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? **Not Applicable.**

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.

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) | | Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition) | | Mia's Simple Fracture (in-network emergency room visit and follow up care) | |
|---|-----------------|---|----------------|--|----------------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$5,400 | ■ The <u>plan's</u> overall <u>deductible</u> | \$5,400 | ■ The <u>plan's</u> overall <u>deductible</u> | \$5,400 |
| ■ <u>Specialist copayment</u> | \$90 | ■ <u>Specialist copayment</u> | \$90 | ■ <u>Specialist copayment</u> | \$90 |
| ■ <u>Hospital (facility) coinsurance</u> | 30% | ■ <u>Hospital (facility) coinsurance</u> | 30% | ■ <u>Hospital (facility) coinsurance</u> | 30% |
| ■ <u>Other copayment</u> | \$50 | ■ <u>Other copayment</u> | \$50 | ■ <u>Other copayment</u> | \$50 |
| <p>This EXAMPLE event includes services like:</p> <p><u>Specialist</u> office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (<i>ultrasounds and blood work</i>) <u>Specialist</u> visit (<i>anesthesia</i>)</p> | | <p>This EXAMPLE event includes services like:</p> <p><u>Primary care physician</u> office visits (<i>including disease education</i>) <u>Diagnostic tests</u> (<i>blood work</i>) Prescription drugs <u>Durable medical equipment</u> (<i>glucose meter</i>)</p> | | <p>This EXAMPLE event includes services like:</p> <p><u>Emergency room care</u> (<i>including medical supplies</i>) <u>Diagnostic test</u> (<i>x-ray</i>) <u>Durable medical equipment</u> (<i>crutches</i>) <u>Rehabilitation services</u> (<i>physical therapy</i>)</p> | |
| Total Example Cost | \$12,700 | Total Example Cost | \$5,600 | Total Example Cost | \$2,800 |
| <p>In this example, Peg would pay:</p> <p style="text-align: center;"><i>Cost Sharing</i></p> | | <p>In this example, Joe would pay:</p> <p style="text-align: center;"><i>Cost Sharing</i></p> | | <p>In this example, Mia would pay:</p> <p style="text-align: center;"><i>Cost Sharing</i></p> | |
| <u>Deductibles</u> | \$5,400 | <u>Deductibles</u> | \$50 | <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$700 | <u>Copayments</u> | \$2,100 | <u>Copayments</u> | \$1,400 |
| <u>Coinsurance</u> | \$1,700 | <u>Coinsurance</u> | \$0 | <u>Coinsurance</u> | \$60 |
| <i>What isn't covered</i> | | <i>What isn't covered</i> | | <i>What isn't covered</i> | |
| Limits or exclusions | \$60 | Limits or exclusions | \$20 | Limits or exclusions | \$0 |
| The total Peg would pay is | \$7,860 | The total Joe would pay is | \$2,170 | The total Mia would pay is | \$1,460 |

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

Get help in your language

Language Assistance Services

Curious to know what all this says? We would be too. Here's the English version: IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD:711)

Separate from our language assistance program, we make documents available in alternative formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos pedirle a alguien que le ayude a leerla. También es posible que pueda solicitar que le enviemos esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721 (TTY/TDD: 711).

Arabic

هام: هل تستطيع قراءة هذه الرسالة؟ إذا لم يكن الأمر كذلك، يمكننا أن نطلب من شخص ما مساعدتك في قراءتها. قد تتمكن أيضاً من الحصول على هذه الرسالة مكتوبة بلغتك للحصول على مساعدة مجانية، يرجى الاتصال على الفور على الرقم 1-888-254-2721. (TTY/TDD: 711)

Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք կարդալ այս նամակը: Եթե ոչ, մենք կարող ենք առաջարկել որևէ մեկի օգնությունը՝ ձեզ համար այն կարդալու համար: Դուք կարող եք նաև այս նամակը ստանալ ձեր լեզվով: Անվճար օգնության համար խնդրում ենք անմիջապես զանգահարել՝ 1-888-254-2721. (TTY/TDD: 711)

Chinese

重要：您能看此信嗎？如果不能，我們可以請人幫您看。您還可以獲得以您的語言寫的此信件。如需免費幫助，請立即致電 1-888-254-2721. (TTY/TDD:711)

Farsi

بخواهیم شخصی از توانیم می ما، توانیدنی اگر بخوانید؟ را نامه این توانید می آیا مهم: کتبی صورت به را نامه این بتوانید است ممکن همچنین. کند کمک شما به آن خواندن در شماره با فوراً لطفاً، رایگان کمک دریافت برای. کنید دریافت خودتان زبان به و بگیرید تماس (1-888-254-2721. (TTY/TDD: 711)

Hindi

महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में किसी की मदद ले सकते हैं। यह पत्र आप अपनी भाषा में भी लिखवा सकते हैं। निःशुल्क सहायता के लिए, कृपया तुरंत 1-888-254-2721 पर कॉल करें। (टीटीवाई/टीडीडी:711)

Hmong

TSEEM CEEB: Koj puas nyeem tau daim ntawv no? Yog tias tsis tau, peb muaj qee tus neeg pab nyeem nws rau koj. Koj los kuj yuav tau txais ib daim ntawv sau ua kom yam lus. Rau kev pab dawb, thov hu tam sim ntawm 1-888-254-2721. (TTY/TDD: 711)

Japanese

重要：この文書を読むことができますか？読むことができない場合、支援することが可能です。また、日本語で訳されたこの文書を書面で受け取ることができます。無料の支援をご希望の場合、1-888-254-2721 (TTY/TDD:711) にご連絡ください。

Khmer

សំខាន់៖ តើអ្នកអាចអានសំបុត្រនេះបានទេ? បើអត់ទេ យើងអាចមានអ្នកជួយអាន។ អ្នកក៏អាចទទួលបានសំបុត្រនេះសរសេរជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយ ឥតគិតថ្លៃ សូមទូរស័ព្ទមកភ្លាមៗតាមរយៈលេខ 1-888-254-2721. (TTY/TDD: 711)

Korean

중요: 이 편지를 읽으실 수 있으신가요? 그렇지 않으신 경우, 이를 읽으실 수 있도록 도움을 제공해 드릴 수 있습니다. 귀하의 모국어로 된 편지를 우편으로 받아보실 수도 있습니다. 무상으로 제공되는 도움이 필요하신 경우, 1-888-254-2721번으로 바로 연락해 주십시오. (TTY/TDD: 711)

Punjabi

ਕੀ ਤੁਸੀਂ ਇਹ ਚਿੱਠੀ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਸ ਚਿੱਠੀ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵੀ ਲਿਖ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਤੁਰੰਤ ਇਸ 'ਤੇ ਕਾਲ ਕਰੋ 1-888-254-2721। (TTY/TDD: 711)

Russian

ВАЖНАЯ ИНФОРМАЦИЯ: Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

Tagalog

MAHALAGA: Mababasa mo ba ang sulat na ito? Kung hindi, mayroon kaming makakatulong sa iyo na basahin ito. Maaari mo ring makuha ang sulat na ito nang nakasulat sa iyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai

สำคัญ: คุณสามารถอ่านจดหมายนี้ได้หรือไม่ หากคุณอ่านจดหมายนี้ไม่ได้ เราสามารถขอให้ ใครสักคนช่วยคุณอ่านได้ คุณสามารถร้องขอ จดหมายนี้ที่เขียนในภาษาของคุณได้เช่นกัน หากต้องการความช่วยเหลือแบบไม่มีค่าใช้จ่าย โปรดโทรหาเราได้ที่ 1-888-254-2721. (TTY/TDD: 711)

Vietnamese

QUAN TRỌNG: Quý vị có đọc được lá thư này không? Nếu không, chúng tôi có thể nhờ ai đó giúp quý vị đọc. Quý vị cũng có thể yêu cầu thư này viết bằng ngôn ngữ của quý vị. Để được trợ giúp miễn phí, hãy gọi ngay đến số 1-888-254-2721. (TTY/TDD: 711)

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