**Summary of Benefits and Coverage:**

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 (877) 737-7776 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>$500/member or $1,000/family for In-Network Providers, $500/member or $1,000/family for Out-of-Network Providers.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. Prescription Drugs, Preventive care, Primary Care visit, and Specialist visit for In-Network Providers.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>Yes. $250/per admission for all inpatient hospitalizations (waived for emergency admission). $50/visit for Emergency room services (waived if admitted directly from ER).</td>
<td>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.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>$2,000/single or $4,000/family for In-Network Providers. No Out-of-Pocket limit when using Out-of-Network Providers. This plan has a separate Out of Pocket Maximum for Prescription Drugs $2,000/single or $4,000/family $1,000 Home delivery.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, Balance-Billing charges, and Health Care this plan doesn't cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></td>
<td>Yes, Prudent Buyer PPO. See <a href="http://www.anthem.com/ca/calpers">www.anthem.com/ca/calpers</a> or call (877) 737-7776 for a list of network providers.</td>
<td>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...</td>
</tr>
</tbody>
</table>
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? No.

You can see the specialist you choose without a referral.

---

Important information: All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$20/visit medical deductible does not apply</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$35/visit medical deductible does not apply</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>$5/34 day supply</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$10/90 day supply</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$20/34 day supply</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$40/90 day supply</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$50/34 day supply</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$100/90 day supply</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Specialty follows the tier structure above</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee e.g. Ambulatory Surgery Center; ASC</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
</tr>
</tbody>
</table>

Services and supplies for the following outpatient surgeries are limited: Colonoscopy limited to $1,500 per procedure; Cataract surgery limited to $2,000 per procedure; Arthroscopy limited to $6,000 per procedure. Benefits limited to $350 for ASC per day for Non-PPO providers.

* For more information about limitations and exceptions, see plan or policy document at www.anthem.com/ca/calpers.
<table>
<thead>
<tr>
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<th>Services You May Need</th>
<th>What You Will Pay</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>PPO Provider</strong></td>
<td><strong>Non-PPO Provider</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>(You will pay the least)</em></td>
<td><em>(You will pay the most)</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Physician/surgeon fees</strong></td>
<td>10% <strong>coinsurance</strong></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>10% <strong>coinsurance</strong></td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>10% <strong>coinsurance</strong></td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$35/visit medical <strong>deductible</strong> does not apply</td>
<td>40% <strong>coinsurance</strong></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% <strong>coinsurance</strong></td>
<td>40% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% <strong>coinsurance</strong></td>
<td>40% <strong>coinsurance</strong></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office Visit $20/visit medical <strong>deductible</strong> does not apply</td>
<td>Other Outpatient 10% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>10% <strong>coinsurance</strong></td>
<td>40% <strong>coinsurance</strong></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>10% <strong>coinsurance</strong></td>
<td>40% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>10% <strong>coinsurance</strong></td>
<td>40% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>10% <strong>coinsurance</strong></td>
<td>40% <strong>coinsurance</strong></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>10% <strong>coinsurance</strong></td>
<td>40% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>10% <strong>coinsurance</strong></td>
<td>40% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>10% <strong>coinsurance</strong></td>
<td>40% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>10% <strong>coinsurance</strong> The first 10 days. 20% <strong>coinsurance</strong> For the next 170 days.</td>
<td>40% <strong>coinsurance</strong></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see [plan](www.anthem.com/ca/calpers) or policy document at [www.anthem.com/ca/calpers](www.anthem.com/ca/calpers).
## Common Medical Event | Services You May Need | What You Will Pay | Limitations, Exceptions, & Other Important Information
--- | --- | --- | ---
|  | Durable medical equipment |  | 
|  | Hospice services |  | 
| If your child needs dental or eye care | Children’s eye exam |  | 
|  | Children’s glasses |  | 
|  | Children’s dental check-up |  | 

### What You Will Pay
- **PPO Provider (You will pay the least)**
- **Non-PPO Provider (You will pay the most)**
  - **Durable medical equipment**
    - 10% coinsurance
    - 40% coinsurance
  - **Hospice services**
    - 10% coinsurance
    - 10% coinsurance
  - **Children’s eye exam**
    - Not covered
    - Not covered
  - **Children’s glasses**
    - Not covered
    - Not covered
  - **Children’s dental check-up**
    - Not covered
    - Not covered

### 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
- Long-term care
- Routine foot care unless you have been diagnosed with diabetes.
- Dental routine care (adult)
- Private-duty nursing
- Weight loss programs
- Infertility treatment
- Routine eye care (adult)

#### 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.
- Hearing aids $1,000 maximum every 36 months.
- Bariatric surgery
- Most coverage provided outside the United States. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)
- Chiropractic care 20 visits/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’s Employee Benefits Security Administration at (866) 444-EBSA (3272) or [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:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, considered an Adverse Benefit Determination (ABD) you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: [Grievance and Appeals](#) 1-877-737-7776 or Anthem Blue Cross Attention: Grievance and Appeals P.O. Box 60007 Los Angeles, CA 90060-0007 If Anthem Blue Cross upholds the ABD, that decision becomes a Final Adverse Benefit Determination (FABD) and you may request an independent External Review. If you are not satisfied with Anthem Blue Cross’ FABD, the independent External Review decision or you do not want to pursue the independent External Review Process, you may request an Administrative Review from CalPERS. The request must be mailed to: CalPERS Health Plan Administration Division/ Health Appeals Coordinator P.O. Box 1953 Sacramento, CA 95812-1953

* For more information about limitations and exceptions, see plan or policy document at [www.anthem.com/ca/calpers](http://www.anthem.com/ca/calpers).
Does this plan provide Minimum Essential Coverage? Yes
If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

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)

- **The plan’s overall deductible**: $500
- **Specialist copayment**: $20
- **Hospital (facility) coinsurance**: 10%
- **Other coinsurance**: 10%

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**: $12,840

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$40</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,480</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $60
- The total Peg would pay is: $3,080

#### Managing Joe’s type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan’s overall deductible**: $500
- **Specialist copayment**: $20
- **Hospital (facility) coinsurance**: 10%
- **Other coinsurance**: 10%

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**: $7,460

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$624</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $31
- The total Joe would pay is: $2,355

#### Mia’s Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan’s overall deductible**: $500
- **Specialist copayment**: $20
- **Hospital (facility) coinsurance**: 10%
- **Other coinsurance**: 10%

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**: $2,010

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$60</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$326</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $0
- The total Mia would pay is: $886

The plan would be responsible for the other costs of these EXAMPLE covered services.
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 (877) 737-7776


Arabic: إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على 777-737-7776.

Armenian (հայերեն): Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկությունները, սպասարկելու համար զանգահարեք (877) 737-7776।

Bassa (Bàsà Wùɖù): Ì dyì dyì-dì-dì bë bêçë bâ céè-dì nià ke dï ni, ò mè nì dyì-dëçëè-dì bë m kê gbô-krà-krà kê bô kpô dë m bìdi-wùɖùn bó pïdyì. Bë m kê wùɖù-zìï-nyô dò gbo wùɖù ke, dá (877) 737-7776.

Bengali (বাঙ্গালি): যদি এই নথিগুলির বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষার বিনামূল্যে সাহায্য পাওয়া ও ভক্তি পাওয়ার অধিকার আপনার আছে। একটি ভাষায় সাথে কথা বলার জন্য (877) 737-7776 -তে কল করুন।

Burmese (မြန်မာ): ကြိုးကျင်မှုများသည် စိတ်ပျော်ရွှေ့ရေး လုပ်ငန်းသည်ကို ပြောင်းလဲအားဖြင့် ကြိုးကျင်မှုများကို ဆောင်ရွက်ရန် သည် အခါမှ အချင်းချင်းများကို အသုံးပြုပါ။ (877) 737-7776 ရှာဖွေပါ။

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 (877) 737-7776。

Dinka (Dinka): Na nong thièee nè ke de yà thorè, ke yin nong loŋ bë yi kuony ku wer akë bë geér yic yin ne thon dë ke cin wëu tàñë ke pîny. Te kôr yin ba jam wënè ran ye thok geryic, ke yin col (877) 737-7776.

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 (877) 737-7776.

Farsi فارسی: در صورتی که سوالی پیرامون این سند داردید، 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 777-737-7776 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 (877) 737-7776.
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 (877) 737-7776.

**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 (877) 737-7776.

**Gujarati (ગુજરાતી):** જો આ દસ્તાવેજને અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ભાષામાં મદદ અને માહહતી મેળવવા તમને અધિકાર છે. દુભાષયા સાથે વાત કરવા માટે, કોલ કરો (877) 737-7776.

**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 (877) 737-7776.

**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। दुभाषियों से बात करने के लिए, कॉल करें (877) 737-7776.

**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 (877) 737-7776.

**Igbo (Igbo):** Ọ bụrụ na i nwere ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweka enyemaka na ozi n'asụsụ ụ bụla. Ka ụtọ na ọkọwa okwu kwuo okwu, kpọ (877) 737-7776.

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