blue of california

Summary of Benefits

Self-Insured Schools of California
Effective October 1, 2025
PPO Plan

ASCIP ASO PPO Plan I Optional

This Summary of Benefits shows the amount you will pay for Covered Services under this Claims Administrator benefit plan. It is only a summary and it is included as part of the Benefit Booklet.[1] Please read both documents carefully for details.

Provider Network: Full PPO Network

This Plan uses a specific network of Health Care Providers, called the Full PPO provider network. Providers in this network are called Participating Providers. You pay less for Covered Services when you use a Participating Provider than when you use a Non-Participating Provider. You can find Participating Providers in this network at blueshieldca.com.

Calendar Year Deductibles (CYD)[2]

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before the Claims Administrator pays for Covered Services under the Plan. The Claims Administrator pays for some Covered Services before the Calendar Year Deductible is met, as noted in the Benefits chart below.

		When using a Participating[3] or Non-Participating[4] Provider
Calendar Year medical Deductible	*Individual coverage*	$250
	Family coverage	$250: individual $500: Family

Calendar Year Out-of-Pocket Maximum[5]

An Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year. Any exceptions are listed in the Notes section at the end of this Summary of Benefits.

	When using a Participating Provider[3]	When using a Non-Participating Provider[4]
Individual coverage	$1,000	$3,000
Family coverage	$1,000: individual $2,000: Family	$3,000: individual $6,000: Family

No Annual or Lifetime Dollar Limit

Under this Plan there is no annual or lifetime dollar limit on the amount Claims Administrator will pay for Covered Services.

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4,9]	CYD[2] applies
Preventive Health Services[7]				
Preventive Health Services	$0		Not covered	
Physician services[10]				
Primary care office visit	$20/visit		30%	✔
Specialist care office visit	$20/visit		30%	✔
Physician home visit	$20/visit		30%	✔
Physician or surgeon services in an Outpatient Facility	10%	✔	30%	✔
Physician or surgeon services in an inpatient facility	10%	✔	30%	✔
Other professional services[10]				
Other practitioner office visit	$20/visit		30%	✔
Includes nurse practitioners, physician assistants, and therapists.				
Acupuncture services	$20/visit	✔	$20/visit	✔
Up to 12 visits per Member, per Calendar Year.				
Chiropractic services	$20/visit		$20/visit plus 30%	
Up to 20 visits per Member, per Calendar Year.				
Family planning				
• Counseling, consulting, and education	$0		Not covered	
• Injectable contraceptive	$0		Not covered	
• Diaphragm fitting	$0		Not covered	
• Intrauterine device (IUD)	$0		Not covered	
• Insertion and/or removal of intrauterine device (IUD)	$0		Not covered	
• Implantable contraceptive	$0		Not covered	
• Tubal ligation	$0		Not covered	
• Vasectomy	10%	✔	Not covered	
• Diagnosis and Treatment of the Cause of Infertility	Not covered		Not covered	
Podiatric services	$20/visit		30%	✔
Medical nutrition therapy, not related to diabetes	10%	✔	30%	✔
Pregnancy and maternity care[7,10]				
Physician office visits: prenatal and postnatal	$20/visit		30%	✔
Physician services for pregnancy termination	10%	✔	Not covered	
Certified nurse midwives	10%	✔	10%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4,9]	CYD[2] applies
Emergency Services				
Emergency room services *If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Participating Provider payment under Inpatient facility services/ Hospital services and stay.*	$50/visit	✔	$50/visit	✔
Emergency room Physician services	10%	✔	10%	✔
Urgent care center services[10]	$20/visit		30%	✔
Ambulance services *This payment is for emergency or authorized transport.*	10%	✔	10%	✔
Outpatient Facility services				
Ambulatory Surgery Center	10%	✔	30% Subject to a Benefit maximum of $350/day	✔
Outpatient Department of a Hospital: surgery	10%	✔	30% Subject to a Benefit maximum of $350/day	✔
Arthroscopy[8]	10% Subject to a Benefit maximum of $4,500/procedure	✔	Not covered	
Cataract Surgery[8]	10% Subject to a Benefit maximum of $2,000/procedure	✔	Not covered	
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	10%	✔	30% Subject to a Benefit maximum of $350/day	✔
Inpatient facility services				
Hospital services and stay	10%	✔	30% Subject to a Benefit maximum of $600/day	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4,9]	CYD[2] applies
Transplant services *This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.*				
• Special transplant facility inpatient services	10%	✔	Not covered	
• Physician inpatient services	10%	✔	Not covered	
Bariatric surgery services, designated California counties *This payment is for bariatric surgery services for residents of designated California counties. For bariatric surgery services for residents of non-designated California counties, the payments for Inpatient facility services/ Hospital services and stay and Physician inpatient and surgery services apply for inpatient services; or, if provided on an outpatient basis, the Outpatient Facility services and outpatient Physician services payments apply.*				
Inpatient facility services	10%	✔	Not covered	
Outpatient Facility services	10%	✔	Not covered	
Physician services	10%	✔	Not covered	
Diagnostic x-ray, imaging, pathology, and laboratory services *This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.*				
Laboratory and pathology services *Includes diagnostic Papanicolaou (Pap) test.*				
• Laboratory center	10%	✔	30%	✔
• Outpatient Department of a Hospital	10%	✔	30% Subject to a Benefit maximum of $350/day	✔
Basic imaging services *Includes plain film X-rays, ultrasounds, and diagnostic mammography.*				
• Outpatient radiology center	10%	✔	30%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4,9]	CYD[2] applies
• Outpatient Department of a Hospital	10%	✔	30% Subject to a Benefit maximum of $350/day	✔
Other outpatient non-invasive diagnostic testing *Testing to diagnose illness or injury such as vestibular function tests, EKG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.*				
• Office location	10%	✔	30%	✔
• Outpatient Department of a Hospital	10%	✔	30% Subject to a Benefit maximum of $350/day	✔
Advanced imaging services *Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.*				
• Outpatient radiology center	10%	✔	30%	✔
• Outpatient Department of a Hospital	10%	✔	30% Subject to a Benefit maximum of $350/day	✔
Colonoscopy[8]	10% Subject to a Benefit maximum of $1,500/procedure	✔	Not covered	
Upper GI Endoscopy[8]	10% Subject to a Benefit maximum of $1,000/procedure	✔	Not covered	
Upper GI Endoscopy with Biopsy[8]	10% Subject to a Benefit maximum of $1,250/procedure	✔	Not covered	
Rehabilitative and Habilitative Services *Includes physical therapy, occupational therapy, and respiratory therapy.*				
Office location	10%	✔	30%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4,9]	CYD[2] applies
Outpatient Department of a Hospital	10%	✔	30%	✔
Speech Therapy services				
Office location	10%	✔	30%	✔
Outpatient Department of a Hospital	10%	✔	30%	✔
Durable medical equipment (DME)				
DME	10%	✔	30%	✔
Breast pump	$0		Not covered	
Orthotic equipment and devices	10%	✔	30%	✔
Up to 2 pairs of shoes and 2 inserts for therapeutic shoes per Calendar Year.				
Prosthetic equipment and devices	10%	✔	30%	✔
Home health care services	10%	✔	Not covered	
Up to 100 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period. Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist, and medical supplies.				
Home infusion and home injectable therapy services				
Home infusion agency services	10%	✔	Not covered	
Includes home infusion drugs, medical supplies, and visits by a nurse.				
Hemophilia home infusion services	10%	✔	Not covered	
Includes blood factor products.				
Skilled Nursing Facility (SNF) services				
Up to 150 days per Member, per benefit period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year.				
Freestanding SNF	10%	✔	10%	✔
Hospital-based SNF	10%	✔	30% Subject to a Benefit maximum of $600/day	✔
Hospice program services				
Pre-Hospice consultation	10%	✔	Not covered	

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4,9]	CYD[2] applies
Routine home care	10%	✔	Not covered	
24-hour continuous home care	10%	✔	Not covered	
Short-term inpatient care for pain and symptom management	10%	✔	Not covered	
Inpatient respite care	10%	✔	Not covered	
Other services and supplies[10]				
Diabetes care services				
• Devices, equipment, and supplies	10%	✔	30%	✔
• Self-management training	$20/visit		30%	✔
• Medical nutrition therapy	$20/visit		30%	✔
Dialysis services	10%	✔	30% Subject to a Benefit maximum of $350/day	✔
PKU product formulas and special food products	10%	✔	Not covered	
Allergy serum billed separately from an office visit	10%	✔	30%	✔
Hearing aid services				
• Hearing aids and equipment *Up to $4,000 combined maximum per Member, per 36-month period.*	10%	✔	10%	✔
• Audiological evaluations	$20/visit		30%	✔

Mental Health and Substance Use Disorder Benefits	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4,9]	CYD[2] applies
Outpatient services				
Office visit, including Physician office visit	$20/visit		30%	✔
Intensive outpatient care	10%	✔	30%	✔
Behavioral Health Treatment in an office setting	10%	✔	30%	✔
Behavioral Health Treatment in home or other non-institutional setting	10%	✔	30%	✔
Office-based opioid treatment	10%	✔	30%	✔
Partial Hospitalization Program	10%	✔	30% Subject to a Benefit maximum of $350/day	✔
Psychological Testing	10%	✔	30%	✔

Mental Health and Substance Use Disorder Benefits	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4,9]	CYD[2] applies
Inpatient services				
Physician inpatient services	10%	✔	30%	✔
Hospital services	10%	✔	30% Subject to a Benefit maximum of $600/day	✔
Residential Care	10%	✔	30% Subject to a Benefit maximum of $600/day	✔

Prior Authorization

The following are some frequently-utilized Benefits that require prior authorization:

- Advanced imaging services
- Outpatient mental health services, except office visits and office-based opioid treatment
- Inpatient facility services
- Hospice program services

Please review the Benefit Booklet for more about Benefits that require prior authorization.

Notes

1 Benefit Booklet:

The Benefit Booklet describes the Benefits, limitations, and exclusions that apply to coverage under this Plan. Please review the Benefit Booklet for more details of coverage outlined in this Summary of Benefits. You can request a copy of the Benefit Booklet at any time.

Capitalized terms are defined in the Benefit Booklet. Refer to the Benefit Booklet for an explanation of the terms used in this Summary of Benefits.

2 Calendar Year Deductible (CYD):

Calendar Year Deductible explained. A Calendar Year Deductible is the amount you pay each Calendar Year before the Claims Administrator pays for Covered Services under the Plan.

If this Plan has any Calendar Year Deductible(s), Covered Services subject to that Deductible are identified with a check mark (✔) in the Benefits chart above.

Covered Services not subject to the Calendar Year medical Deductible. Some Covered Services received from Participating Providers are paid by the Claims Administrator before you meet any Calendar Year medical Deductible. These Covered Services do not have a check mark (✔) next to them in the "CYD applies" column in the Benefits chart above.

This Plan has a combined Participating Provider and Non-Participating Provider Calendar Year Deductible.

Notes

Family coverage has an individual Deductible within the Family Deductible. This means that the Deductible will be met for an individual with Family coverage who meets the individual Deductible prior to the Family meeting the Family Deductible within a Calendar Year.

3 Using Participating Providers:

Participating Providers have a contract to provide health care services to Members. When you receive Covered Services from a Participating Provider, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

"Allowable Amount" is defined in the Benefit Booklet. In addition:

- Coinsurance is calculated from the Allowable Amount.
- Any charges above the specified Benefit maximum are not covered, do not count towards the Out-of-Pocket Maximum, and are your responsibility for payment to the provider.

4 Using Non-Participating Providers:

Non-Participating Providers do not have a contract to provide health care services to Members. When you receive Covered Services from a Non-Participating Provider, you are responsible for:

- the Copayment or Coinsurance (once any Calendar Year Deductible has been met), and
- any charges above the Allowable Amount.

"Allowable Amount" is defined in the Benefit Booklet. In addition:

- Coinsurance is calculated from the Allowable Amount, which is subject to any stated Benefit maximum.
- Charges above the Allowable Amount do not count towards the Out-of-Pocket Maximum, and are your responsibility for payment to the provider. This out-of-pocket expense can be significant.
- Some Benefits from Non-Participating Providers have the Allowable Amount or Benefit maximum listed in the Benefits chart as a specific dollar ($) amount. You are responsible for any charges above the Allowable Amount or Benefit maximum, whether or not an amount is listed in the Benefits chart.

5 Calendar Year Out-of-Pocket Maximum (OOPM):

Calendar Year Out-of-Pocket Maximum explained. The Out-of-Pocket Maximum is the most you are required to pay for Covered Services in a Calendar Year. Once you reach your Out-of-Pocket Maximum, the Claims Administrator will pay 100% of the Allowable Amount for Covered Services for the rest of the Calendar Year.

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges for services that are not covered and charges above the Allowable Amount.

Any Deductibles count towards the OOPM. Any amounts you pay that count towards the medical Calendar Year Deductible also count towards the Calendar Year Out-of-Pocket Maximum.

This benefit Plan has a separate Participating Provider OOPM and Non-Participating Provider OOPM. However, only the following Non-Participating Provider services will accrue to the OOPM:

- Ambulance services;
- Emergency services;
- Certified Nurse Midwives;
- Skilled nursing facilities (SNF) services at a Freestanding SNF; and
- Hearing aids and equipment.

Family coverage has an individual OOPM within the Family OOPM. This means that the OOPM will be met for an individual with Family coverage who meets the individual OOPM prior to the Family meeting the Family OOPM within a Calendar Year.

Notes

6 Separate Member Payments When Multiple Covered Services are Received:

Each time you receive multiple Covered Services, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance. For example, you may owe an office visit payment in addition to an allergy serum payment when you visit the doctor for an allergy shot.

7 Preventive Health Services:

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit. If you receive both Preventive Health Services and other Covered Services during the Physician office visit, you may have a Copayment or Coinsurance for the visit.

8 Outpatient Facility Services

Services and supplies for the following Outpatient surgeries are subject to a Benefit maximum if performed in the Outpatient department of a Hospital: athroscopy, cataract surgery, colonoscopy, upper GI endoscopy, and upper GI endoscopy with biopsy. The Benefit maximum does not apply when the same services are provided in a participating Ambulatory Surgery Center.

9 For Services by Non-Preferred, Non-Participating Providers:

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit. If you receive both Preventive Health Services and other Covered Services during the Physician office visit, you may have a Copayment or Coinsurance for the visit.

You are responsible for all charges above the Allowable Amount. However, if the Non-Preferred/Non-Participat-ing Provider is a Hospital based Physician performing Services at a Participating (in-network) facility; or out of network lab services, when performed by an in-network (participating) provider, but sent to a non-participating provider for processing, the Claims Administrator's payment will be made at the Participating Provider copayment level.

Authorized Referrals for Services by Non-Preferred/Non-Participating Providers –

In some circumstances, the Claims Administrator may authorize participating provider cost share amounts (Deductibles or Co-Payments, if applicable) to apply to a claim for a covered service you receive from a non-participating provider. In such circumstance, you or your physician must contact the Claims Administrator in advance of obtaining the covered service. It is your responsibility to ensure that the Claims Administrator has been contacted. If the Claims Administrator authorizes a participating provider cost share amount to apply to a covered service received from a non-participating provider, you also may still be liable for the difference between the maximum allowed amount and the non-participating provider's charge. Please call the customer service telephone number on the back of your ID card for authorized referral information or to request authorization.

Authorized referral occurs when you, because of your medical needs, are referred to a non-participating provider, but only when:

a. There is no participating provider who practices in the appropriate specialty, which provides the required services, or which has the necessary facilities within a 50-mile radius of your residence;
b. You are referred in writing to the non-participating provider by the physician who is a participating provider, and
c. The referral has been authorized by the Claims Administrator before services are rendered. You or your physi-cian must call the toll-free telephone number printed on the back of your identification card prior to scheduling an admission to, or receiving the services of, a non-participating provider. Such authorized referrals are not available for transplant and bariatric surgical services. These services are only covered when performed at a COE.

Notes

10 First Dollar Coverage:

This Plan offers first dollar coverage for 3 office visits with Participating Providers. This means the Claims Administrator will pay for these Covered Services before you are charged a Copayment.

First dollar coverage is available for office visits with a Participating Physician, for any combination of these Provider types:

- General practice
- Family practice
- Internal Medicine
- Pediatrics
- Nurse Practitioner
- Physician's Assistant
- Obstetrics
- Gynecology

After you reach the 3 office visit maximum under the first dollar coverage benefit, additional office visits in the same Calendar Year are subject to the applicable Participating Provider office visit Copayment.

Non-Participating Provider office visits are not covered under the first dollar coverage. These services are covered as described in the Benefits chart above.

Plans may be modified to ensure compliance with Federal requirements.

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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, you can get the complete terms in the policy or plan document at www.anthem.com/ca/sisc or by calling 1-855-333-5730. 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 1-855-333-5730 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$250 per individual / $500 per family. Does not apply to preventative care and prescription drugs.	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.
Are there services covered before you meet your deductible?	Yes. Preventative care, primary care, and prescription drug coverage services are covered before you meet your deductible	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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	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.
What is the out-of-pocket limit for this plan?	For network providers: $1,000 individual / $2,000 family for medical. For out-of-network providers: $3,000 individual / $6,000 family for medical. $2,500 individual / $3,500 family for prescription drug coverage	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.
What is not included in the out-of-pocket limit?	Copayments for certain 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. For a list of network providers, see blueshieldca.com/fad or call 1-855-599-2657.	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.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
		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	$0 / visit (first three visits) $20 / visit thereafter Deductible does not apply	30% coinsurance	None
	Specialist Visit	$20 / visit Deductible does not apply	30% coinsurance	None
	Preventive care/screening/ immunization	No Charge Deductible does not apply	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Outpatient Radiology Center: 30% coinsurance Outpatient Hospital: 30% coinsurance with $350/day max	Preauthorization is required.
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.navitus.com**	Generic drugs	Costco 30-Days: $0/Rx Other 30-Days: $10/Rx Mail 90-Days: $25/Rx	Member must pay the entire cost up front and apply for reimbursement. Net cost may be greater than if member uses an in-network provider.	Some narcotic pain medications and cough medications require the regular retail copayment at Costco and 3 times the regular copayment at Mail.
	Preferred brand drugs	Preferred: Costco 30-Days: $20/Rx Other 30-Days: $20/Rx Mail 90-Days: $45/Rx Non-Preferred: Costco 30-Days: $35/Rx Other 30-Days: $35/Rx		If a brand drug is dispensed when a generic equivalent is available, then the member will be responsible for the generic copayment plus the cost difference between the generic and brand.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-network provider (You will pay the most)	
		Mail 90-Days: $90/Rx		
	Specialty drugs	Follows Generic, Preferred, & Non-Preferred Costs Above	Not Covered	Member must use Navitus Specialty Rx. Supplies of more than 30 days are not allowed
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance with $350/day max	In-network hospital benefit limitations: Arthroscopy: $4,500/procedure Cataract Surgery: $2,000/procedure Colonoscopy: $1,500/procedure Upper GI Endoscopy w/Biopsy: $1,250/procedure Upper GI Endoscopy w/o Biopsy: $1,000/procedure Coverage is limited to $350/admit for out-of-network Ambulatory Surgery Centers.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$50 / visit	$50 / visit	$100 Copayment waived if admitted. You are responsible for billed charges exceeding maximum allowed amount for out-of-network providers.
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	$20 / visit Deductible does not apply	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance subject to a benefit maximum of $600/day	The maximum plan payment for non-emergency hospital services received from a non-preferred hospital is $600 per day. Members are responsible for all charges in excess of $600. Failure to preauthorize may result in reduced

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-network provider (You will pay the most)	
				or nonpayment of benefits.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: $20 / visit Deductible does not apply Facility: 10% coinsurance	Office Visit: 30% coinsurance Other Outpatient Services: 30% coinsurance Partial Hospitalization: 30% coinsurance subject to a benefit maximum of $350/day *Psychological Testing*: 30% coinsurance	Preauthorization is required except for office visits and office-based opioid treatment. Failure to obtain preauthorization may result in non-payment of benefits.
	Inpatient services	10% coinsurance	Physician Inpatient Services: 30% coinsurance Hospital Services: 30% coinsurance subject to a benefit maximum of $600/day Residential Care: 30% coinsurance subject to a benefit maximum of $600/day	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
If you are pregnant	Office visits	$20 / visit Deductible does not apply	30% coinsurance	Cost sharing does not apply for preventative services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	None
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance subject to a benefit maximum of $600/day	Non-Preferred facility are subject to a maximum benefit payment up to $600 per day.
If you need help recovering or have	Home health care	10% coinsurance	Not Covered	Preauthorization is required. Failure to obtain preauthorization may result in

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-network provider (You will pay the most)	
other special health needs				non-payment of benefits. Coverage limited to 100 visits per member per Calendar Year.
	Rehabilitation services	10% coinsurance	30% coinsurance subject to a benefit maximum of $350/day	None
	Habilitation services	10% coinsurance	30% coinsurance subject to a benefit maximum of $350/day	None
	Skilled nursing care	10% coinsurance	Freestanding SNF: 10% coinsurance Hospital-based SNF: 30% coinsurance subject to a benefit maximum of $600/day	Covers up to 100 days per calendar year combined with Hospital Skilled Nursing Facility Unit. Preauthorization is required. Failure to preauthorize may result in reduced or nonpayment of benefits.
	Durable medical equipment	10% coinsurance	30% coinsurance	Preauthorization is required. Therapeutic shoes & inserts for members with diabetes (2 pairs each/calendar year).
	Hospice services	No Charge	Not Covered	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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 eye care (Adult/Child)
• Dental care (Adult/Child)	• Routine foot care	• Services not deemed medically necessary
• Infertility treatment	• Private -duty nursing	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Bariatric surgery	• Chiropractic care
• Hearing aids		

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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or cciio.cms.gov. 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:

Anthem BlueCross
ATTN: Appeals
P.O. Box 4310
Woodland Hills, CA 91365-4310

Or Contact: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform

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.

Language Access Services:

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.

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。

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.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł 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.

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 section.