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, call 1-800-528-1530. 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.mybenemax.com keyword: **POSEIDON** or call 1-800-528-1530 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0** in-network; **$12,000** individual/ **$24,000** family out-of-network	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 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. In-network care. For more information see below.	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 don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For medical and prescription drug benefits, **$0** member / **$0** family in-network; **$14,100** member / **$28,200** family out-of-network	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 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?	Premiums, balanced-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes, Prudent Buyer PPO See http://www.anthem.com/ca or call (855) 383-7248 for a list of network providers. Costs may vary by site of service and how the provider bills.	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?	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 Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge; deductible does not apply	50% coinsurance	Deductible applies out-of-network; Virtual visits (Telehealth) benefits available.
	Specialist visit	No charge; deductible does not apply	50% coinsurance	Deductible applies out-of-network; Virtual visits (Telehealth) benefits available.
	Preventive care/screening/ immunization	No charge; deductible does not apply	50% coinsurance	Deductible applies out-of-network; You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge; deductible does not apply	50% coinsurance	Deductible applies out-of-network
	Imaging (CT/PET scans, MRIs)	No charge; deductible does not apply	50% coinsurance	Deductible applies out-of-network; $380 maximum/admission for Non-Network Providers.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.anthem.com/pharmacyinformation	Generic drugs	No charge; deductible does not apply	Not covered	Deductible applies out-of-network except for certain value drugs; up to 30-day retail (90-day mail service) supply; cost share may be waived for certain covered drugs and supplies; preauthorization required for certain drugs
	Preferred brand drugs	No charge; deductible does not apply	Not covered	
	Non-preferred brand drugs	No charge; deductible does not apply	Not covered	
	Specialty drugs	No charge; deductible does not apply	Not covered	Deductible applies out-of-network; when obtained from a designated specialty pharmacy; preauthorization required for certain value drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge; deductible does not apply	50% coinsurance	Deductible applies out-of-network; $380 maximum/admission for Non-Network Providers.
	Physician/surgeon fees	No charge; deductible does not apply	50% coinsurance	Deductible applies out-of-network
If you need immediate medical attention	Emergency room care	No charge; deductible does not apply	No charge; deductible does not apply	None
	Emergency medical transportation	No charge; deductible does not apply	No charge; deductible does not apply	Non-emergency non-network Ambulance Services are limited to $50,000 per occurrence.
	Urgent care	No charge; deductible does not apply	50% coinsurance	Deductible applies out-of-network

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge; deductible does not apply	50% coinsurance	Deductible applies out-of-network; $650 maximum/day for Non- Network Providers.
	Physician/surgeon fees	No charge; deductible does not apply	50% coinsurance	Deductible applies out-of-network
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge; deductible does not apply	50% coinsurance	Deductible applies out-of-network; Virtual visits (Telehealth) benefits available.
	Inpatient services	No charge; deductible does not apply	50% coinsurance	Deductible applies out-of-network; $650 maximum/day for Non- Network Providers. 50% coinsurance for Inpatient Physician Fee Non- Network Providers.
If you are pregnant	Office visits	No charge; deductible does not apply	50% coinsurance	Deductible applies out-of-network; cost sharing does not apply for preventive services; 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	No charge; deductible does not apply	50% coinsurance	
	Childbirth/delivery facility services	No charge; deductible does not apply	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge; deductible does not apply	50% coinsurance	Deductible applies out-of-network; $75 maximum/visit for Non- Network Providers. 100 visits/year for Home Health and Private Duty Nursing combined for In-Network and Non-Network Providers combined.
	Rehabilitation services	No charge; deductible does not apply	50% coinsurance	Deductible applies out-of-network; *see Therapy Services section.
	Habilitation services	No charge; deductible does not apply	50% coinsurance	
	Skilled nursing care	No charge; deductible does not apply	50% coinsurance	Deductible applies out-of-network; $150 maximum/day for Non-Network Providers. 100 days/benefit period for skilled nursing services for In-Network and Non-Network Providers combined.
	Durable medical equipment	No charge; deductible does not apply	50% coinsurance	Deductible applies out-of-network; * See Durable Medical Equipment Section
	Hospice services	No charge; deductible does not apply	50% coinsurance	Deductible applies out-of-network

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	 Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If your child needs dental or eye care	Children's eye exam	No charge; deductible does not apply	$0 copayment up to plan's Maximum Allowed Amount; deductible does not apply	Deductible applies out-of-network; *See Vision Services section
	Children's glasses	No charge; deductible does not apply	$0 copayment up to plan's Maximum Allowed Amount; deductible does not apply	
	Children's dental check-up	No charge; deductible does not apply	0% coinsurance	Deductible applies out-of-network; *See Dental Services section

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)
- Hearing Aids
- Infertility treatment
- Long-term care
- Routine foot care unless medically necessary
- 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 20 visits/year
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Private-duty nursing 100 visits/year combined with Home Health
- Routine eye care (adult) 1 exam/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 Managed Health Care, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, (888) 466-2219, https://www.dmhc.ca.gov/, Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform, 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 http://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: Grievances and Appeals, P.O. Box 4310, Woodland Hills, CA 91365-4310
Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform

* For more information about limitations and exceptions, see the plan or policy document at www.mybenemax.com keyword: **POSEIDON**

Department of Managed Health Care, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, (888) 466-2219, https://www.dmhc.ca.gov/
California Consumer Assistance Program, Operated by the California Department of Managed Health Care, 980 9th St, Suite #500, Sacramento, CA 95814, (888) 466-2219, https://www.dmhc.ca.gov/

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	$0
■ Delivery fee copay	$0
■ Facility fee copay	$0
■ Diagnostic tests copay	$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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
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)

■ The plan's overall deductible	$0
■ Specialist visit copay	$0
■ Primary care visit copay	$0
■ Diagnostic tests copay	$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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$20**

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

■ The plan's overall deductible	$0
■ Specialist visit copay	$0
■ Emergency room copay	$0
■ Ambulance services copay	$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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$0**

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