



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/5YUQSH08152024276500MG04>. 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 (855) 296-0864 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	\$150/person or \$450/family. All <b>Providers</b>	Generally, you must pay all of the costs from <b>providers</b> up to the <b>deductible</b> amount before this <b>plan</b> begins to pay. If you have other family members on the <b>plan</b> , each family member must meet their own individual <b>deductible</b> until the total amount of <b>deductible</b> expenses paid by all family members meets the overall family <b>deductible</b> .
<b>Are there services covered before you meet your deductible?</b>	Yes. Primary Care <b>Specialist</b> Visit <b>Preventive Care</b> for In- <b>Network Providers</b> . Tier 1 Tier 2 Tier 3 Tier 4 <b>Prescription Drugs</b> for In- <b>Network</b> and Non- <b>Network Providers</b> . Pediatric Dental & Vision for In- <b>Network</b> and Non- <b>Network Providers</b> .	This <b>plan</b> covers some items and services even if you haven't yet met the <b>deductible</b> amount. But a <b>copayment</b> or <b>coinsurance</b> may apply. For example, this <b>plan</b> covers certain <b>preventive services</b> without <b>cost-sharing</b> and before you meet your <b>deductible</b> . See a list of covered <b>preventive services</b> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <b>deductibles</b> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	\$5,350/person or \$10,700/family for In- <b>Network Providers</b> . \$20,000/person or \$40,000/family for Non- <b>Network Providers</b> .	The <b>out-of-pocket limit</b> is the most you could pay in a year for covered services. If you have other family members in this <b>plan</b> , they have to meet their own <b>out-of-pocket limits</b> until the overall family <b>out-of-pocket limit</b> has been met.
<b>What is not included in the out-of-pocket limit?</b>	<b>Premiums</b> , <b>balance-billing</b> charges, and health care this <b>plan</b> doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
<b>Will you pay less if you use a network</b>	Yes, Prudent Buyer PPO. See <a href="http://www.anthem.com/ca/h">http://www.anthem.com/ca/h</a>	This <b>plan</b> uses a <b>provider network</b> . You will pay less if you use a <b>provider</b> in the <b>plan's network</b> . You will pay the most if you use an <b>Out-of-Network Provider</b> , and you might

<b>provider?</b>	<a href="#">ealth-insurance/provider-directory/searchcriteria?planstate=CA&amp;plantype=PPOSTUD&amp;planname=Blue+Cross+PPO+Prudent+Buyer+-+Student+Health</a> or call (855) 296-0864 for a list of <a href="#">network providers</a> . Costs may vary by site of service and how the provider bills.	receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">Out-of-Network Provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	Yes.	When you need medical care, you must first go to the Student Health Center (SHC).

 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)	Non-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$30/visit <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	Services must be provided or referred by the Student Health Center for students. See the certificate for details.
	<a href="#">Specialist</a> visit	\$30/visit <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	Services must be provided or referred by the Student Health Center for students. See the certificate for details.
	<a href="#">Preventive care</a> / <a href="#">screening</a> / <a href="#">immunization</a>	No charge	40% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. Services must be provided or referred by the Student Health Center for students. See the certificate for details.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://eoc.anthem.com/eocdps/ca/5YUQSH08152024276500MG04>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Precertification required for some services. For details about precertification, see the certificate.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Precertification required for some services. For details about precertification, see the certificate.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="https://fm.fornu.larynavigator.com/FBO/143/Traditional_ABC_4_Tier_Student_Health_Plan.pdf">https://fm.fornu.larynavigator.com/FBO/143/Traditional_ABC_4_Tier_Student_Health_Plan.pdf</a> Traditional Open Drug List	Tier 1 - Typically Generic	\$25/prescription, <a href="#">deductible</a> does not apply (retail and home delivery)	\$25/prescription plus 50% <a href="#">coinsurance</a> up to a \$250 maximum (retail) <a href="#">deductible</a> does not apply	Most home delivery is 90-day supply. *See Prescription Drug section of the <a href="#">plan</a> or policy document (e.g. evidence of coverage or certificate).
	Tier 2 - Typically <a href="#">Preferred Brand</a> & Non- <a href="#">Preferred Generic</a> Drugs	\$50/prescription, <a href="#">deductible</a> does not apply (retail) and \$100/prescription, <a href="#">deductible</a> does not apply (home delivery)	\$50/prescription plus 50% <a href="#">coinsurance</a> up to a \$250 maximum (retail) <a href="#">deductible</a> does not apply	
	Tier 3 - Typically Non- <a href="#">Preferred Brand</a> and Generic drugs	\$50/prescription, <a href="#">deductible</a> does not apply (retail) and \$100/prescription, <a href="#">deductible</a> does not apply (home delivery)	\$50/prescription plus 50% <a href="#">coinsurance</a> up to a \$250 maximum (retail) <a href="#">deductible</a> does not apply	
	Tier 4 - Typically <a href="#">Preferred Specialty</a> (brand and generic)	\$50/prescription, <a href="#">deductible</a> does not apply (retail) and \$100/prescription, <a href="#">deductible</a> does not apply (home delivery)	\$50/prescription plus 50% <a href="#">coinsurance</a> up to a \$250 maximum (retail) <a href="#">deductible</a> does not apply	

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Precertification required for most surgical procedures. For details about precertification, see the certificate.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$100/visit, then 20% <a href="#">coinsurance</a>	Covered as In- <a href="#">Network</a>	Copay waived if admitted.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	Covered as In- <a href="#">Network</a>	-----none-----
	<a href="#">Urgent care</a>	\$30/visit <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	\$500/admission, then 40% <a href="#">coinsurance</a>	Precertification required for inpatient facility admissions and most surgical procedures. For details about precertification, see the certificate. An additional <b>\$500</b> penalty applies for Non- <a href="#">Network</a> hospital if precertification not obtained; waived for emergency admission.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit \$30/visit <a href="#">deductible</a> does not apply Other Outpatient 20% <a href="#">coinsurance</a>	Office Visit 40% <a href="#">coinsurance</a> Other Outpatient 40% <a href="#">coinsurance</a>	Office Visit -----none----- Other Outpatient -----none-----
	Inpatient services	20% <a href="#">coinsurance</a>	\$500/admission, then 40% <a href="#">coinsurance</a>	Precertification required for inpatient facility admissions. For details about precertification, see the certificate. An additional <b>\$500</b> penalty applies for Non-

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
				<a href="#">Network Provider</a> , if precertification not obtained; waived for emergency admission.
If you are pregnant	Office visits	Routine office visits: No charge Office visits related to complications: \$30/visit <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	No charge for Preventive prenatal and postnatal care for In- <a href="#">Network Providers</a> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	\$500/admission, then 40% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	100 visits/benefit period Precertification required. For details about precertification, see the certificate. Limit applies separately to <a href="#">Rehabilitation</a> and <a href="#">Habilitation</a> services.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	See “If you have a hospital stay” for applicable Inpatient cost share. *See Therapy Services section. Services must be provided or referred by the Student Health Center for students. See the certificate for details.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	100 days/benefit period Precertification required. For details about precertification, see the certificate.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	*See <a href="#">Durable Medical Equipment</a> Section. Services

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
				must be provided or referred by the Student Health Center for students. See the certificate for details.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Precertification required. For details about precertification, see the certificate.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	Reimbursed Up to \$30	*See Vision Services section
	Children's glasses	No charge	Reimbursed Up to \$55	
	Children's dental check-up	No charge	No charge	*See Dental Services section

**Excluded Services & Other Covered Services:**

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other excluded services.)		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Long-term care</li> <li>• Weight loss programs</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care (Adult)</li> <li>• Routine eye care (Adult)</li> <li>• Private-duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Routine foot care unless you have been diagnosed with diabetes</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Hearing aids one hearing aid/ear every three years.</li> </ul>	<ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Most coverage provided outside the United States. See <a href="http://www.bcbsglobalcore.com">www.bcbsglobalcore.com</a></li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care 30 visits/benefit period</li> <li>• Abortion</li> </ul>

**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: California Department of Insurance, Consumer Services Division, 300 South Spring Street, South Tower, Los Angeles, CA 90013, (800) 927-HELP (4357) , 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](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](#)

\* For more information about limitations and exceptions, see the [plan](#) or policy document at

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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

California Department of Insurance, Consumer Services Division, 300 South Spring Street, South Tower, Los Angeles, CA 90013, (800) 927-HELP (4357)

California Department of Insurance, Consumer Communications Bureau, 300 South Spring Street, South Tower, Los Angeles, CA 90013, 1-800-927-HELP (4357), 1-213-897-8921, 1-800-482-4TDD (4633), [www.insurance.ca.gov/](http://www.insurance.ca.gov/)

**Does this plan provide Minimum Essential Coverage? Yes/No**

[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/No**

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.*

\* For more information about limitations and exceptions, see the [plan](#) or policy document at

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## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$150	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$150	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$150
■ <a href="#">Specialist copayment</a>	\$30	■ <a href="#">Specialist copayment</a>	\$30	■ <a href="#">Specialist copayment</a>	\$30
■ Hospital (facility) <a href="#">coinsurance</a>	20%	■ Hospital (facility) <a href="#">coinsurance</a>	20%	■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%	■ Other <a href="#">coinsurance</a>	20%	■ Other <a href="#">coinsurance</a>	20%
<p>This EXAMPLE event includes services like:</p> <p><a href="#">Specialist</a> office visits (<i>prenatal care</i>)            Childbirth/Delivery Professional Services            Childbirth/Delivery Facility Services  <a href="#">Diagnostic tests</a> (<i>ultrasounds and blood work</i>)  <a href="#">Specialist</a> visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like:</p> <p><a href="#">Primary care physician</a> office visits (<i>including disease education</i>)  <a href="#">Diagnostic tests</a> (<i>blood work</i>)  <a href="#">Prescription drugs</a>  <a href="#">Durable medical equipment</a> (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like:</p> <p><a href="#">Emergency room care</a> (<i>including medical supplies</i>)  <a href="#">Diagnostic test</a> (<i>x-ray</i>)  <a href="#">Durable medical equipment</a> (<i>crutches</i>)  <a href="#">Rehabilitation services</a> (<i>physical therapy</i>)</p>	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<a href="#">Cost Sharing</a>		<a href="#">Cost Sharing</a>		<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$150	<a href="#">Deductibles</a>	\$100	<a href="#">Deductibles</a>	\$150
<a href="#">Copayments</a>	\$10	<a href="#">Copayments</a>	\$1,700	<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$2,000	<a href="#">Coinsurance</a>	\$0	<a href="#">Coinsurance</a>	\$400
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$2,700	Limits or exclusions	\$20	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$4,860</b>	<b>The total Joe would pay is</b>	<b>\$1,820</b>	<b>The total Mia would pay is</b>	<b>\$750</b>

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 (855) 296-0864

**Amharic (አማርኛ):** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 296-0864 ይደውሉ።

. Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (855) 296-0864.

**Armenian (հայերեն):** Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (855) 296-0864:

**Bassa (Bàsɔ̀ Wùdù):** M̄ dyi dyi-diè-dɛ̀ bɛ̀ bédé b́á céè-dɛ̀ nìà kɛ dyí ní, ɔ̀ m̀d̀ nì dyí-bédɛ̀in-dɛ̀ bɛ̀ m̀ kɛ̀ gbo-kpá-kpá kè b̄́ kp̄́ dɛ̀ m̀ bídí-wùdù̀n b́ó pídyi. B́é m̀ kɛ̀ wuɖu-zìin-nyò d̀ò gbo wùdù kɛ, d́á (855) 296-0864.

**Bengali (বাংলা):** যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্য সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (855) 296-0864 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖု (855) 296-0864 သို့ ခေါ်ဆိုပါ။

**Chinese (中文):** 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(855) 296-0864。

**Dinka (Dinka):** Na nɔŋ thiëc në ke de yā thorë, ke yin nɔŋ loŋ bē yi kuony ku wɛr alëu bē gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kɔr yin ba jam wënë ran ye thok geryic, ke yin cɔl (855) 296-0864.

**Dutch (Nederlands):** Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (855) 296-0864.

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## Language Access Services:

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ເພື່ອໂອ້ນລັບກ່ຽວກັບພາສາ, ໃຫ້ໂທຫາ (855) 296-0864.

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