Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Anthem Blue Cross: City of Los Angeles Vivity HMO 15/100% (Los Angeles and Orange Counties)

Coverage Period: 01/01/2020 – 12/31/2020
Coverage for: Individual + Family | Plan Type: HMO

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/cityofla](http://www.anthem.com/ca/cityofla) 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 (844) 348-6110 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0.</td>
<td>See the Common Medical Events chart below for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>No.</td>
<td>You will have to meet the deductible before the plan pays for any services.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don't have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$500/single or $1,500/family for In- Network Providers.</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>What is not included in the out-of-pocket limit?</td>
<td>Infertility services, 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>Will you pay less if you use a network provider?</td>
<td>Yes, Vivity. See <a href="http://www.anthem.com/ca/cityofla">www.anthem.com/ca/cityofla</a> or call (844) 348-6110 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 might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>Yes.</td>
<td>This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.</td>
</tr>
</tbody>
</table>

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>In-Network Provider (You will pay the least): $15/visit</td>
<td>--------none--------</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>Non-Network Provider (You will pay the most): Not covered</td>
<td>--------none--------</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>In-Network Provider (You will pay the least): No charge</td>
<td>--------none--------</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>Non-Network Provider (You will pay the most): Not covered</td>
<td>--------none--------</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1 - Typically Generic</td>
<td>In-Network Provider (You will pay the least): $10/prescription (retail) plus 50% of the remaining prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowed amount up to a $250 maximum/prescription</td>
<td>Most home delivery is 90-day supply. *See Prescription Drug section of the plan or policy document (e.g. evidence of coverage or certificate).</td>
</tr>
<tr>
<td></td>
<td>Tier 2 - Typically Preferred/Brand</td>
<td>Non-Network Provider (You will pay the most): $20/prescription (retail) 50% of the remaining prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowed amount up to a $250 maximum/prescription</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 3 - Typically Non-Preferred/Specialty Drugs</td>
<td>Non-Network Provider (You will pay the most): $40/prescription (retail) 50% of the remaining prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowed amount</td>
<td></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan or policy document at www.anthem.com/ca/cityofla.
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<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Non-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>up to a $250 maximum/prescription</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Tier 4 - Typically <strong>Specialty Drugs</strong> (brand and generic)</td>
<td>$40/prescription (retail)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td><strong>Emergency room care</strong></td>
<td>$100/visit</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td></td>
<td><strong>Emergency medical transportation</strong></td>
<td>No charge</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td></td>
<td><strong>Urgent care</strong></td>
<td>$15/visit</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office Visit</td>
<td>Office Visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$15/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Inpatient services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$15/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Habilitation services</td>
<td>$15/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
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<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Non-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td><strong>Hospice services</strong></td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Children’s eye exam</strong></td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Children’s glasses</strong></td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Children’s dental check-up</strong></td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

### 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
- Eye exams for a child
- Long-term care
- Routine eye care (adult)
- Dental care (adult)
- Glasses for a child
- Non-emergency care when traveling outside the U.S.
- Routine foot care unless you have been diagnosed with diabetes.
- Dental Check-up
- 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.)

- Abortion
- Chiropractic care 60 visits/benefit period combined with Acupuncture.
- Acupuncture 60 visits/benefit period combined with Chiropractic care.
- Hearing aids one hearing aid/car every 24 months.
- Bariatric surgery

* For more information about limitations and exceptions, see plan or policy document at www.anthem.com/ca/cityofla.
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) HMO-2219. Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), 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 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
Department of Managed Health Care, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, (888) HMO-2219
California Department of Managed Health Care Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814, (888) 466-2219, www.healthhelp.ca.gov, helpline@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.

* For more information about limitations and exceptions, see plan or policy document at www.anthem.com/ca/cityofla.
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
- Specialist **copayment**: $15
- Hospital (facility) **coinsurance**: 0%
- Other **coinsurance**: 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**: $12,800

**Cost Sharing**

<table>
<thead>
<tr>
<th></th>
<th>Peg would pay</th>
<th>Joe would pay</th>
<th>Mia would pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Copayments</strong></td>
<td>$70</td>
<td>$500</td>
<td>$400</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $60
- The total Peg would pay is: $130

In this example, Peg would pay: $130

### 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 **copayment**: $15
- Hospital (facility) **coinsurance**: 0%
- Other **coinsurance**: 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**: $7,400

**Cost Sharing**

<table>
<thead>
<tr>
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<th>Peg would pay</th>
<th>Joe would pay</th>
<th>Mia would pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Copayments</strong></td>
<td>$70</td>
<td>$500</td>
<td>$400</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $60
- The total Joe would pay is: $560

In this example, Joe would pay: $560

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

- The **plan’s overall deductible**: $0
- Specialist **copayment**: $15
- Hospital (facility) **coinsurance**: 0%
- Other **coinsurance**: 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**: $1,900

**Cost Sharing**

<table>
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<th>Joe would pay</th>
<th>Mia would pay</th>
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<tbody>
<tr>
<td><strong>Deductibles</strong></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Copayments</strong></td>
<td>$500</td>
<td>$400</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $60
- The total Mia would pay is: $400

In this example, Mia would pay: $400

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 (844) 348-6110

Amharic (አማርኛ): የCESS እንፋን በወንሮ የዓለም ገብሬታቸውን ሰጥቶ እንከ የእናከት የስደኩስ በትለት ወስኗትን እንከ ይሁን ከምструктур ከህግ ይህታል። ይህም ከምክር ከማረጋገር (844) 348-6110 ይታችላል።

Armenian (հայերեն): Եթե իս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճարը ստանալ օգնություն և տեղեկություն: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (844) 348-6110:

Basa (Bàsà Wúdù): M dyi dyi-die-dè bè bëcé bá cée-dè nià ke dyí ni, c mò ni dyi-bèqèin-dè bè m ké gbo-kpá-kpá ké bò kpö dé m bidji-wùdùún bó pидyi. Bè m ké wuɗu-zin-nyò dò gbo wùdù ke, dá (844) 348-6110.

Bengali (বাংলা): যদি এই নথিগুলির বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষার বিনামূল্য সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দীর্ঘকালীন সাথে কথা বলার জন্য (844) 348-6110 -তে কল করুন।

Burmese (မြန်မာ့): သင် သင်ခြင်းများ ဆက်ဆံရေး ၏ အခြေ အနေအထိုးများ ရှင်းပြသည်။ သင် သင်၏ အခြေအနေအထိုးများ ရှင်းပြသည်။ အကြမ်းဖက်များက အထွေထွေအခြေအနေအထိုးများကို (844) 348-6110 သို့ ဆိုလျော်လျော်ပါ။

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 (844) 348-6110。

Dinka (Dinka): Na naŋ thëëc nê ke de yà thoré, ke yin naŋ long bë yi kuony kwo ñlè bë geër yin ne thon du ke cin wëñ tæaë ke piny. Te kor yin ba jam wëñe ran ye thok geryic, ke yin col (844) 348-6110.

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 (844) 348-6110.

Farsi (فارسی): در صورتی که سوالی پیرامون این سند داردید، این حق را داردید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (844) 348-6110 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 (844) 348-6110.
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 (844) 348-6110.

**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 (844) 348-6110.

**Gujarati (ગુજરાતી):** જો આ દસ્તાવેજ અને આપને ગુજરાતી ભાષામાં મદદ અને માહહતી મેળવવાનો તમને અધિકાર છે. દુભાંધાપણા સાથે વાત કરવા માટે, કોલ કરો (844) 348-6110.

**Haitian Creole (Kreyòl Ayisyen):** Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn ed ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (844) 348-6110.

**Hindi (हिंदी):** अगर आपके पास इस दस्तावेज के बारे में कोई प्रश्न है, तो आपको निश्चित अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभांधापण रूप से बात करने के लिए, कॉल करें (844) 348-6110.

**Hmong (White Hmong):** Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lusqhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (844) 348-6110.

**Igbo (Igbo):** Ọ bụrụ na ọ nwere ajụjụ ọ bula gbasara akwụkwọ a, ọ nwere ikike ịnweta enyemaka na ozi n'asụsụ gi na akwụghị ụgwọ ọ bula. Ka gi nọkwọ okwu kwuo okwu, kpọ (844) 348-6110.

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**Italian (Italiano):** In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (844) 348-6110.

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Lao (ภาษาลาว): ถ้าคุณมีคำถามเกี่ยวกับเนื้อหาหรือข้อมูลเกี่ยวกับเนื้อหา คุณสามารถสอบถามได้ โดยมีบริการแปลและต้อนรับเรื่องที่เกี่ยวข้อง ที่ที่คุณต้องการมีบริการ โทร (844) 348-6110.

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