CharterLIFE™
Believe Build Benefit

Anthem Blue Cross High PPO

Your summary of benefits

Anthem BlueCross

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Your Plan: Essential Formulary $5/$15/$25/$45/30%

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Certificate of Insurance or Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	$0	$0
Pharmacy Out of Pocket	Combined with medical out of pocket	Combined with medical out of pocket
Prescription Drug Coverage *This plan uses an Essential formulary List. Drugs not on the list are not covered.* *You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days.*		
Tier1 - Typically Generic *Covers up to a 30 day supply (retail pharmacy).* *Covers up to a 90 day supply (home delivery program).*	Tier1a Typically Lower Cost Generic $5 copay per prescription (retail only) and $12.50 copay per prescription (home delivery only) Tier1b Typically Generic $15 copay per prescription (retail only) and $37.50 copay per prescription (home delivery only)	Tier 1a 50% coinsurance up to $250 per prescription (retail only) Tier 1b 50% coinsurance up to $250 per prescription (retail only)

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Tier2 - Typically Preferred / Brand *Covers up to a 30 day supply (retail pharmacy).* *Covers up to a 90 day supply (home delivery program).*	Tier 2 Typically Preferred Brand & non-preferred generic drugs $25 copay per prescription (retail only) and $75 copay per prescription (home delivery only)	Tier 2 50% coinsurance up to $250 per prescription (retail only)
Tier3 - Typically Non-Preferred / Specialty Drugs *Covers up to a 30 day supply (retail pharmacy).* *Covers up to a 90 day supply (home delivery program).*	Tier 3 Typically Non-Preferred Brand and generic drugs $45 copay per prescription (retail only) and $135 copay per prescription (home delivery only)	Tier 3 50% coinsurance up to $250 per prescription (retail only)
Tier4 - Typically Specialty Drugs *Classified specialty drugs must be obtained through our Specialty Pharmacy Program and are subject to the terms of the program.* *Covers up to a 30 day supply (retail pharmacy and home delivery program).*	Tier 4 Typically Specialty (brand and generic) 30% coinsurance up to $250 per prescription (retail and home delivery)	Tier 4 50% coinsurance up to $250 per prescription (retail only)

Your summary of benefits

Notes:

- When using non-network pharmacy; members are responsible for 50% of the prescription drug maximum allowed amount & costs in excess of the prescription drug maximum allowed amount. Members will pay upfront and submit a claim form.
- Supply limits for certain drugs may be different, go to Anthem website or call customer service.
- Certain drugs require pre-authorization approval to obtain coverage.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.brmsclaims.com. 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.brmsclaims.com or call 1-844-277-8284 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**In-Network: $500** Individual / **$1,000** Family **Out of Network: $1,000** Individual / **$2,000** Family	Generally, you must pay all 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.** Preventive care services, office visits, prescription drugs, and Telemedicine visits.	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?	**In-Network: $1,500** Individual / **$3,000** Family **Out of Network: $3,000** Individual / **$6,000** Family	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?	Premiums, balance-billed charges, penalties for failure to obtain pre-authorization, infertility treatment 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.** See www.anthem.com/ca or call Benefit & Risk Management Services at 1-866-755-6651 for a list of network providers.	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		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	$20 copay / visit deductible does not apply	30% coinsurance	None
	Specialist visit	$20 copay / visit deductible does not apply		
	Preventive care/screening/ immunization	No charge	30% coinsurance	None
	Anthem Live Health Online	No copay / visit deductible does not apply	30% coinsurance	Telemedicine services provided by a primary care physician or specialist will be covered the same as any other office visit with that provider.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance after deductible	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	30% coinsurance	$800 maximum / service for Non-Network Providers.

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.welldynerx.com	Generic drugs	Tier1a: Retail: $5 copay / prescription Mail Order: $12.50 copay / prescription Tier1b: Retail: $15 copay / prescription Mail Order: $37.50 copay / prescription	Retail: 50% coinsurance up to $250 / prescription Mail Order: Not Covered	Covers up to a 30-day supply (retail); 90-day supply (mail order)
	Preferred brand drugs	Retail: $25 copay / prescription Mail Order: $75 copay / prescription	Retail: 50% coinsurance up to $250 / prescription Mail Order: Not Covered	Covers up to a 30-day supply (retail); 90-day supply (mail order)
	Non-preferred brand drugs	Retail: $45 copay / prescription Mail Order: $135 copay / prescription	Retail: 50% coinsurance up to $250 / prescription Mail Order: Not Covered	Covers up to a 30-day supply (retail); 90-day supply (mail order)
	Specialty drugs	Retail & Mail Order: 30% coinsurance up to $250 per prescription	Retail: 50% coinsurance up to $250 / prescription Mail Order: Not Covered	Covers up to a 30-day supply. Specialty drugs must be obtained through US Specialty Care Pharmacy (USSC) after one fill at a participating retail pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	30% coinsurance	$350 maximum / service for Non-Network Providers
	Physician/surgeon fees	10% coinsurance after deductible	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$150 / visit then 10% coinsurance after deductible	Covered as In-Network	Copay waived if admitted. 10% coinsurance for Emergency Room Physician Fee.
	Emergency medical transportation	10% coinsurance after deductible	Covered as In-Network	None

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)	
	Urgent care	$20 copay / office visit Deductible does not apply	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible	30% coinsurance	$1,000 maximum / day for Non-Emergency Admissions to Non-Network Providers
	Physician/surgeon fees	10% coinsurance after deductible	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay / office visit 10% coinsurance after deductible / outpatient	30% coinsurance	None
	Inpatient services	10% coinsurance after deductible	30% coinsurance	$1,000 maximum/day for Non-Emergency Admissions to Non-Network Providers. 10% coinsurance for Inpatient Physician Fee In-Network Providers. 30% coinsurance for Inpatient Physician Fee Non-Network Providers.
If you are pregnant	Office visits	$20 copay / initial visit deductible does not apply	30% coinsurance	$1,000 maximum/day for Non-Emergency Admissions to Non-Network Providers. 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	10% coinsurance after deductible	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance after deductible	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance after deductible	30% coinsurance	100 visits/benefit period one visit by a home health aide equals four hours or less.
	Rehabilitation services	10% coinsurance after deductible	30% coinsurance	*See Therapy Services section.
	Habilitation services	10% coinsurance after deductible	30% coinsurance	*See Therapy Services section.
	Skilled nursing care	10% coinsurance after deductible	30% coinsurance	Must commence within 14 days of an inpatient hospital stay that is at least 3 days. Limited to 100 days per calendar year.
	Durable medical equipment	10% coinsurance after deductible	30% coinsurance	None

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)	
	Hospice services	No copay / visit deductible does not apply	30% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Refer to Vision Plan
	Children's glasses	Not Covered	Not Covered	Refer to Vision Plan
	Children's dental check-up	Not Covered	Not Covered	Refer to Dental Plan

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 check-up
- Dental care (Adult)
- Eye exams for a child
- Infertility treatment
- Long term care
- Glasses for a child
- Dental care (Pediatric)
- Routine eye care (Adult)
- Routine foot care unless you have been diagnosed with diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture 20 visits / benefit period
- Hearing aids
- Bariatric surgery
- Private duty nurse (In-Network only)
- Chiropractic care 30 visits/benefit period
- Most coverage provided outside the United States. See www.bcbsglobalcore.com

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 the plan at 1-844-277-8284, the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or https://www.cms.gov/cciio. 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 https://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: the plan at 1-844-277-8284. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or https://www.dol.gov/agencies/ebsa.

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 844-277-8284.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 844-277-8284.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 844-277-8284.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 844-277-8284.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other (generic pharmacy) copayment	$10

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,738**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$10
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,970**

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

The plan's overall deductible	$500
Specialist copayment	$30
Hospital (facility) coinsurance	20%
Other (brand pharmacy) copayment	$30

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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$800
Coinsurance	$80
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,400**

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

The plan's overall deductible	$500
Specialist copay	$50
Hospital (facility) coinsurance	20%
Other (DME) coinsurance	20%

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	$500
Copayments	$200
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

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