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 1-866-995-2372. 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.dol.gov/ebsa/healthreform or www.cciio.cms.gov or call 1-866-995-2372 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your cost for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Preventive care, primary care services and most outpatient services are covered before you meet the 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?	Yes. $250 for inpatient hospital admission, inpatient mental health and substance abuse, skilled nursing care. There are other specific deductibles.	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?	$2,000 individual / $4,000 family. Prescription Drug $8,600 individual / $17,200 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-billing charges, prescription penalties, 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 1-866-995-2372 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 form a provider for the difference between the provider's charge and what you 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
		PPO Provider (You will pay the least)	Non-PPO 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	$40 copay/visit; deductible does not apply	None
	Specialist visit	$20 copay/visit; deductible does not apply	$40 copay/visit; deductible does not apply	None
	Preventive care/screening/ immunization	No charge; deductible does not apply	No charge; deductible does not apply	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	No charge	None
	Imaging (CT/PET scans, MRIs)	No charge	No charge	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	$10 copay/Rx (30-day supply), $20 copay/Rx (90-day supply)	$10 copay/Rx (30-day supply), $20 copay/Rx (90-day supply)	$50 copay/prescription after 3rd refill if available and not purchased at Mail Order, Walgreens or CVS (90-day supply).
	Preferred Brand drugs	$35 copay/Rx (30-day supply), $70 copay/Rx (90-day supply)	$35 copay/Rx (30-day supply), $70 copay/Rx (90-day supply)	$50 copay/prescription after 3rd refill if available and not purchased at Mail Order, Walgreens or CVS (90-day supply).
	Non-Preferred Brand drugs	$70 copay/Rx (30-day supply), $140 copay/Rx (90-day supply)	$70 copay/Rx (30-day supply), $140 copay/Rx (90-day supply)	$50 copay/prescription after 3rd refill if available and not purchased at Mail Order, Walgreens or CVS (90-day supply).
	Specialty drugs	20% copay/Rx	20% copay/Rx	$200 maximum per 30 day supply copay.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$20 copay/visit; deductible does not apply	$40 copay/visit and 20% coinsurance; deductible does not apply	Non-PPO surgical facility limited to $3,000. Preauthorization is required 3 days prior to scheduled outpatient surgery.
	Physician/surgeon fees	$20 copay/visit; deductible does not apply	$40 copay/visit; deductible does not apply	None
If you need immediate medical attention	Emergency room care	$100 copay/visit; deductible does not apply	$100 copay/visit; deductible does not apply	Copay is waived if admitted.
	Emergency medical transportation	No charge	No charge	20% coinsurance for non-emergency transport. Air ambulance and non-emergency transport require preauthorization.

* For more information about limitations and exceptions, see the plan or policy document at www.healthcomp.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
	Urgent care	$20 copay/visit; deductible does not apply	$40 copay/visit; deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance for the 1st $5,000 then no charge	30% coinsurance	Preauthorization is required 3 days prior to a scheduled admission, 48 hours after an emergency admission.
	Physician/surgeon fees	No charge	No charge	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit; deductible does not apply	$40 copay/visit; deductible does not apply	Mental Health outpatient is limited to 1 visit per day.
	Inpatient services	10% coinsurance for the 1st $5,000 then no charge	30% coinsurance	None
If you are pregnant	Office visits	No charge	No charge	Cost sharing does not apply to preventative services.
	Childbirth/delivery professional services	No charge	No charge	
	Childbirth/delivery facility services	$250 copay/pregnancy; deductible does not apply	30% coinsurance	$250 deductible applies to Non-PPO.
If you need help recovering or have other special health needs	Home health care	$20 copay/visit; deductible does not apply	$40 copay/visit then 20% coinsurance; deductible does not apply	None
	Rehabilitation services	$20 copay/visit; deductible does not apply	$40 copay/visit; deductible does not apply	None
	Habilitation services	$20 copay/visit; deductible does not apply	$40 copay/visit; deductible does not apply	None
	Skilled nursing care	No charge	No charge	$250 deductible applies.
	Durable medical equipment	No charge; deductible does not apply	20% coinsurance; deductible does not apply	Coverage is limited to $350 for one wig.
	Hospice services	$20 copay/visit; deductible does not apply	$40 copay/visit; deductible does not apply	None
If your child needs dental or eye care	Children's eye exam	$10 copay	$10 copay	Coverage limited to one exam/year.
	Children's glasses	No charge	No charge	Coverage limited to frames/every other year.
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-ups.

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)
- Weight loss programs

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

- Acupuncture (limited to $1,000 per calendar yr.)
- Bariatric surgery (limited to $5,000 per lifetime)
- Chiropractic care (limited to $80 per day, 1 visit per day, $2,500 per year)
- Hearing Aids (limited to $3,000 every 24 months)
- Infertility treatment (limited to $10,000 per person, per lifetime)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care
- Routine foot care

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: US Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.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 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: Personify Health at: 1-866-995-2372.

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 1-866-995-2372.

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
Specialist copayment	$20
Hospital (facility) coinsurance	10%
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$10
Coinsurance	$700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,020**

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	$20
Hospital (facility) coinsurance	10%
Other (Brand drugs) copayment	$35

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	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$820**

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

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (ER) copayment	$100
Other (Physical Therapy) copayment	$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	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$200**

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