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, please call Benefit and Risk Management Services at (877) 713-2917 or visit us at www.MyHealthBenefits.com. For general definitions of common terms, such as allowed amount, balance billing, co-insurance, co-payment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.HealthCare.gov/Glossary, or call (877) 713-2917 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $2,000 individual / $4,000 family	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 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, In-Network Preventive Care,Office Visits, including Specialist and Outpatient Mental Health, Emergency Care, Urgent Care and Rehabilitation, Habilitation and Rx Services are covered before you meet your 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: $4,000 individual / $8,000 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, any amount over the allowable amount for Out-of-Network charges that result in balance-billing and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use an in-network provider?	Yes. See www.anthem.com/ca or call (877) 713-2917 for a list of network providers.	The plan uses a provider network. You will pay less if you use a provider in the plan's network. You pay more 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 in-network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you receive services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **Co-payment** and **Co-insurance** 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)	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	$30 copayment, deductible waived	Not Covered	None
	Specialist Visit	$50 copayment, deductible waived	Not Covered	None
	Preventive Care, Screening, Immunization	No Charge, Deductible Waived	Not Covered	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 (e.g., X-Ray, Blood Work)	20% coinsurance, after deductible	Not Covered	None
	Imaging (e.g., CT/PET Scans, MRIs)	20% coinsurance, after deductible	Not Covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at	Generic Drugs	Retail: $10 copayment Mail Order:$20 copayment Deductible Waived	Not Covered	Retail: Up to a 31-day supply. Mail-Order*: Up to a 90-day supply. *or Preferred 90-Day Retail Network Pharmacy You may need to obtain certain drugs, including certain specialty drugs, from a
	Preferred Brand Drugs	Retail: $40 copayment Mail Order:$80 copayment Deductible Waived	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
www.optumrx.com.	Non-Preferred Brand Drugs	Retail: $75 copayment Mail Order:$150 copayment Deductible Waived	Not Covered	pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	Specialty Drugs	20% coinsurance, with $20 minimum and $200 maximum/prescription Deductible Waived	Not Covered	
If you have outpatient surgery	Facility Fee (e.g., Ambulatory Surgery Center)	20% coinsurance, after deductible	Not Covered	Pre-certification may be required.
	Physician/Surgeon Fees	20% coinsurance, after deductible	Not Covered	None
If you need immediate medical attention	Emergency Room Care	$125 copayment, deductible waived	$125 copayment, deductible waived	Out-of-Network is covered as In-Network. No coverage for non-emergency use.
	Emergency Medical Transportation	20% coinsurance, after deductible	20% coinsurance, after deductible	Out-of-Network is covered as In-Network. Non-emergency transport, not covered unless Pre-certification is obtained.
	Urgent Care	$50 copayment, deductible waived	Not Covered	No coverage for non-urgent use.
If you have a hospital stay	Facility Fee (e.g., Hospital Room)	$500 copayment plus 20% coinsurance, after deductible	Not Covered	Pre-certification is required.
	Physician/Surgeon Fees	20% coinsurance, after deductible	Not Covered	None
If you need mental health, behavioral health, or substance	Outpatient Services	Office: $30 copayment, deductible waived Other outpatient services:	Not Covered	Pre-certification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
abuse services		No Charge, after deductible		
	Inpatient Services	$500 copayment plus 20% coinsurance, after deductible	Not Covered	Pre-certification is required.
If you are pregnant	Routine Prenatal Office Visits	No Charge, after deductible	Not Covered	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC. (i.e. ultrasound)
	Childbirth/Delivery Professional Services	20% coinsurance, after deductible	Not Covered	None
	Childbirth/Delivery Facility Services	$500 copayment plus 20% coinsurance, after deductible	Not Covered	Precertification is required for stay exceeding 48 hours after standard delivery or 96 hours after C-section.
If you need help recovering or have other special health needs	Home Health Care	20% coinsurance, after deductible	Not Covered	Limited to 120 visits per calendar year. Pre-certification is required
	Rehabilitation Services	$50 copayment, deductible waived	Not Covered	None
	Habilitation Services	$50 copayment, deductible waived	Not Covered	None
	Skilled Nursing Care	$500 copayment plus 20% coinsurance, after deductible	Not Covered	Limited to 60 days per calendar year. Pre-certification is required
	Durable Medical Equipment	20% coinsurance, after deductible	Not Covered	Limited to 1 Durable Medical Equipment for same/similar purpose Excludes repairs for misuse/abuse. Pre-certification may be required
	Hospice Services	20% coinsurance, after deductible	Not Covered	Pre-certification is required

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's Eye Exam	No Charge, after deductible	Not Covered	One routine eye exam per 24 months.
	Children's Glasses	Not Covered	Not Covered	
	Children's Dental Check-Up	Not Covered	Not Covered	

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 and Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Acupuncture (10 visits per calendar year for disease, injury and chronic pain)
- Bariatric surgery
- Chiropractic care (20 visits per calendar year)
- Infertility Treatment (Limited to the diagnosis and treatment of underlying medical condition)
- Routine eye care (Adult – 1 routine eye exam per 24 months)

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 Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.DOL.gov/Agencies/EBSA. 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 on how 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:

Benefit & Risk Management Services
P.O. Box 2140
Folsom, CA 95673

* For more information about limitations and exceptions, see the plan or policy document at www.myhealthbenefits.com or call (877) 713-2917.

Does this plan provide Minimum Essential Coverage? **Yes**
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**
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 (877) 713-2917.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (877) 713-2917.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 (877) 713-2917.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (877) 713-2917.

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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, co-payments and co-insurance) 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 prenatal care and a hospital delivery)

The plan's overall deductible	$2,000
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$2,000
Co-payments	$500
Co-insurance	$1,600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,060**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,000
Specialist coinsurance	$50
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$900
Co-payments	$1,000
Co-insurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,920**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,000
Specialist coinsurance	$50
Hospital (facility) coinsurance	20%
Other 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	$1,700
Co-payments	$500
Co-insurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,200**

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

* For more information about limitations and exceptions, see the plan or policy document at www.myhealthbenefits.com or call (877) 713-2917.