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: $3,300 individual / $6,600 family Out-of-network: $3,300 individual / $6,600 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 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 Out-of-network: $6,000 individual / $12,000 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, penalties for failure to obtain precertification 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	10% coinsurance, after deductible	30% coinsurance, after deductible	None
	Specialist Visit	10% coinsurance, after deductible	30% coinsurance, after deductible	None
	Preventive Care, Screening, Immunization	No Charge, Deductible Waived	30% coinsurance, after deductible	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)	10% coinsurance, after deductible	30% coinsurance, after deductible	None
	Imaging (e.g., CT/PET Scans, MRIs)	10% coinsurance, after deductible	30% coinsurance, after deductible	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.optumrx.com**.	Generic Drugs	10% coinsurance, after deductible, up to maximum/prescription: $10 Retail $20 Mail Order	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 pharmacy designated by us.
	Preferred Brand Drugs	30% coinsurance, after deductible, up to	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)	
		maximum/prescription: $75 Retail $150 Mail Order		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. Prescription drug costs are subject to the annual deductible.
	Non-Preferred Brand Drugs	50% coinsurance, after deductible, up to maximum/prescription: $100 Retail $200 Mail Order	Not Covered	
	Specialty Drugs	20% coinsurance, after deductible, with $20 minimum and $200 maximum/prescription	Not Covered	
If you have outpatient surgery	Facility Fee (e.g., Ambulatory Surgery Center)	10% coinsurance, after deductible	30% coinsurance, after deductible	Pre-certification may be required.
	Physician/Surgeon Fees	10% coinsurance, after deductible	30% coinsurance, after deductible	None
If you need immediate medical attention	Emergency Room Care	10% coinsurance, after deductible	10% coinsurance, after deductible	Out-of-Network is covered as In-Network. No coverage for non-emergency use.
	Emergency Medical Transportation	10% coinsurance, after deductible	10% coinsurance, after deductible	Out-of-Network is covered as In-Network. No coverage for non-emergency use.
	Urgent Care	10% coinsurance, after deductible	30% coinsurance, after deductible	No coverage for non-urgent use.
If you have a hospital stay	Facility Fee (e.g., Hospital Room)	10% coinsurance, after deductible	30% coinsurance, after deductible	Pre-certification is required.
	Physician/Surgeon Fees	10% coinsurance, after deductible	30% coinsurance, after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient Services	Office:10% coinsurance, after deductible Other outpatient services: No Charge, after	Office and other outpatient services: 30% coinsurance, after deductible	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)	
		deductible		
	Inpatient Services	10% coinsurance, after deductible	30% coinsurance, after deductible	Pre-certification is required.
If you are pregnant	Routine Prenatal Office Visits	No Charge, after deductible	30% coinsurance, after deductible	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	10% coinsurance, after deductible	30% coinsurance, after deductible	None
	Childbirth/Delivery Facility Services	10% coinsurance, after deductible	30% coinsurance, after deductible	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	10% coinsurance, after deductible	30% coinsurance, after deductible	Limited to 120 visits per calendar year. Pre-certification is required
	Rehabilitation Services	10% coinsurance, after deductible	30% coinsurance, after deductible	None
	Habilitation Services	10% coinsurance, after deductible	30% coinsurance, after deductible	None
	Skilled Nursing Care	10% coinsurance, after deductible	30% coinsurance, after deductible	Limited to 120 days per calendar year. Pre-certification is required
	Durable Medical Equipment	10% coinsurance, after deductible	30% coinsurance, after deductible	Limited to 1 Durable Medical Equipment for same/similar purpose Excludes repairs for misuse/abuse. 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)	
	Hospice Services	10% coinsurance, after deductible	30% coinsurance, after deductible	Pre-certification is required
If your child needs dental or eye care	Children's Eye Exam	No Charge, after deductible	30% coinsurance, after deductible	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
(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	**$3,000**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**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	**$12,700**
In this example, Peg would pay:	
Cost-sharing	
Deductibles	$3,000
Co-payments	$10
Co-insurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,070**

Managing Joe's Type 2 Diabetes

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

The plan's overall deductible	**$3,000**
Specialist coinsurance	**10%**
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	$3,000
Co-payments	$600
Co-insurance	$80
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,700**

Mia's Simple Fracture

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

The plan's overall deductible	**$3,000**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	$2,800
Co-payments	$0
Co-insurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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.