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 Anthem at 1- 855-567-4698. 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 https://www.healthcare.gov/sbc-glossary/ or call 1- 855-567-4698 to request a copy. If there is a conflict between the SBC and the plan document, the plan document determines the benefits.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,400 single / $2,800 family in-network. $4,200 single / $8,400 family out-of-network.	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, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. 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?	$3,000 single / $6,000 family in-network. $8,000 single / $16,000 family out-of-network.	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, 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 855-567-4698 for a list of participating 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% Coinsurance After Deductible	40% Coinsurance After Deductible	Chiropractic care maximum of 20 visits; Walk in Retail Health Clinics have 20% Coinsurance After Deductible in-network and 40% Coinsurance After Deductible out-of-network; Tele-Health Services have 20% Coinsurance After Deductible in-network and N/A out-of-network.
	Specialist visit	20% Coinsurance After Deductible	40% Coinsurance After Deductible	None
	Preventive care/screening/ immunization	No charge	40% Coinsurance After Deductible	None
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance After Deductible	40% Coinsurance After Deductible	None
	Imaging (CT/PET scans, MRIs)	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Preauthorization is required or a $300 penalty applies
If you need drugs to help manage or treat your illness or condition More information about **prescription drug coverage** is available at **http://www.caremark.com** or 844-232-2329	Generic drugs	Retail: 15% Coinsurance After Deductible (minimum $4, maximum $10) Mail: 15% Coinsurance After Deductible (minimum $10, maximum $25)	Reimbursement is based on network-negotiated price of medication. You pay the full amount in excess of network price.	Retail and Specialty Pharmacy: Up to 30-day supply. Mail Order or CVS Pharmacy Prescription Drugs: Up to 90-day supply. Maintenance drugs: After three retail fills, you will need to fill a 90-day supply through CVS Caremark mail order, or at a CVS retail pharmacy; otherwise you will pay the full negotiated price of the prescription. Certain preventive drugs not subject to the deductible.
	Preferred brand drugs	Retail: 15% Coinsurance After Deductible (minimum $15, maximum $40) Mail: 15% Coinsurance After Deductible (minimum $35, maximum $100)		
	Non-preferred brand drugs	Retail: 15% Coinsurance After Deductible (minimum $30, maximum $60) Mail:		

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)	
		15% Coinsurance After Deductible (minimum $75, maximum $150)		
	Specialty drugs	Same as Retail copayment for Generic and Brand drugs above		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Preauthorization is required or a $300 penalty applies
	Physician/surgeon fees	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Preauthorization is required or a $300 penalty applies
If you need immediate medical attention	Emergency room care	20% Coinsurance After Deductible	20% Coinsurance After Deductible	None
	Emergency medical transportation	20% Coinsurance After Deductible	20% Coinsurance After Deductible	None
	Urgent care	20% Coinsurance After Deductible	40% Coinsurance After Deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Preauthorization is required or a $300 penalty applies
	Physician/surgeon fees	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Preauthorization is required or a $300 penalty applies
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% Coinsurance After Deductible	40% Coinsurance After Deductible	None
	Inpatient services	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Preauthorization is required or a $300 penalty applies
If you are pregnant	Office visits	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance, copayment or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Preauthorization is required for childbirth/delivery or a $300 penalty applies.
	Childbirth/delivery professional services	20% Coinsurance After Deductible	40% Coinsurance After Deductible	
	Childbirth/delivery facility services	20% Coinsurance After Deductible	40% Coinsurance After Deductible	
If you need help recovering or have other special health	Home health care	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Up to 120 visits per calendar year. Preauthorization is required or a $300 penalty 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)	
needs	Rehabilitation services	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Covered as medically necessary; 60 visit annual limit for occupation and physical therapy combined; 25 annual visit limit for speech therapy
	Habilitation services	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Subject to carrier guidelines
	Skilled nursing care	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Up to 100 days per calendar year. Preauthorization is required or a $300 penalty applies
	Durable medical equipment	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Preauthorization is required or a $300 penalty applies
	Hospice services	20% Coinsurance After Deductible	40% Coinsurance After Deductible	Preauthorization is required or a $300 penalty may apply
If your child needs dental or eye care	Children's eye exam	No charge	40% Coinsurance After Deductible	Routine eye exam is a covered benefit if performed by a licensed Ophthalmologist or Optometrist.
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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.)

- Children's eye glasses and dental check-ups
- Cosmetic surgery - unless clinically eligible
- Dental care (Child and Adult) - unless due to treatment related to accidental injury within 12 months of an accident
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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
- Bariatric surgery
- Chiropractic care – up to 20 visits per calendar year
- Habilitation Services, subject to carrier guidelines
- Hearing Aids, up to $1,000 lifetime
- Infertility treatment, up to $5,000 lifetime maximum ($2,500 for medical services and $2,500 for prescriptions)
- Private-duty nursing (if medically necessary)
- Routine eye care (Adult)

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/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: Anthem at 1-855-567-4698 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 1-888-858-4772.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-858-4772.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-888-858-4772.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-858-4772.

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	$1,400
Specialist coinsurance	20%
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,400
Copayments	$0
Coinsurance	$1,600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

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

The plan's overall deductible	$1,400
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$1,400
Copayments	$0
Coinsurance	$1,008
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,463**

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

The plan's overall deductible	$1,400
Specialist coinsurance	20%
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,400
Copayments	$0
Coinsurance	$105
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,505**

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