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 1-800-442-7247 or www.healthcomp.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 https://www.healthcare.gov/sbc-glossary/ or call 1-800-442-7247 to request a copy.

Important Questions	Answers		Why This Matters:
What is the overall deductible?	**Network** None	**Non-Network** $250/Individual $500/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, Non-Network Chiropractic care, Emergency Room, Ambulance.		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 www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	Yes. $50/Individual $150/Family for dental coverage. There are no 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?	**Network** $1,500/Individual $3,000/Family	**Non-Network** $2,500/Individual $5,000Family	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.
	Prescription Drug $7,200/Individual $14,400/Family		
What is not included in the out-of-pocket limit?	Non-Network copays, balance-billed charges, premiums, cost containment penalties, chiropractic care, and health care this plan does not 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 1-800-888-8288 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 a Non-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 a Non-Network provider for some services (such as lab work). Check with your provider before you get services.

Important Questions	Answers	Why This Matters:
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)	Non-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/visit	30% coinsurance	None
	Specialist visit	$30/visit	30% coinsurance	None
	Preventive care/screening/ immunization	No charge	Not covered except for the services listed here →	Non-Network benefits limited to; Contraceptive methods and Routine well child care up to age 19. 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 (x-ray, blood work)	10% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.express-scripts.com/	Generic drugs	Retail: $10/prescription Mail order: $20/prescription		Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). The copay for oral contraceptives is $0.
	Preferred brand drugs	Retail: $20/prescription Mail order: $40/prescription		Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). Diabetes medication available at Walgreens for $10/prescription. When filling diabetes medications at a non-Walgreens pharmacy, the brand copay will apply after two refills.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-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 https://www.express-scripts.com/	Non-preferred brand drugs	Retail: $40/prescription Mail order: $80/prescription		Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription).
	Specialty drugs	**Generic** $20/prescription **Brand** $40/prescription	**Generic** $20/prescription **Brand** $40/prescription	May fill Specialty drugs through Accredo specialty drug program. Visit https://www.accredo.com/
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100/visit	30% coinsurance	Non-Network benefit is limited to $1,000/surgery. Preauthorization is required or coverage may be reduced.
	Physician/surgeon fees	No charge	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$100/visit		Copay waived if admitted. Non-Network deductible waived.
	Emergency medical transportation	No charge	No charge	Non-Network deductible waived.
	Urgent care	$20/visit	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$150/per day up to $750 maximum per calendar year.	30% coinsurance	Preauthorization is required or coverage may be reduced.
	Physician/surgeon fees	No charge	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20/visit	30% coinsurance	None
	Inpatient services	$150/per day up to $750 maximum per calendar year.	30% coinsurance	Preauthorization is required or coverage may be reduced.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you are pregnant	Office visits	$20/visit	30% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	30% coinsurance	
	Childbirth/delivery facility services	$150/per day up to $750 maximum per calendar year.	30% coinsurance	Preauthorization is only required for stay exceeding 48 hours after delivery (or 96 hours after C-section.). When preauthorization is required, coverage may be reduced if not obtained.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Coverage is limited to 40 combined visits per calendar year. Preauthorization is required or coverage may be reduced.
	Rehabilitation services	$20/visit	30% coinsurance	Coverage is limited to 60 visits combined per calendar year.
	Habilitation services	$20/visit	30% coinsurance	Coverage is limited to 60 visits combined per calendar year.
	Skilled nursing care	10% coinsurance	30% coinsurance	Coverage is limited to 120 days per calendar year. Preauthorization is required or coverage may be reduced.
	Durable medical equipment	No charge	30% coinsurance	Preauthorization required for amounts over $500. Preauthorization is required or coverage may be reduced.
	Hospice services	No charge	30% coinsurance	Coverage is limited to $7,500/lifetime for non-network facilities. Preauthorization is required or coverage may be reduced.
If your child needs dental or eye care	Children's eye exam	$20/visit	$20/visit	Coverage is through VSP. Coverage is limited to $35 for Non-Network providers. Limited to one exam per year.
	Children's glasses	$20/pair lenses	$20/pair lenses	Coverage is through VSP. Coverage is limited to $115 for frames from an Network provider. Coverage is limited to $70 for frames,$50 for single lenses, $75 bifocal, $100 trifocal, $75 progressive from a Non-Network provider. Limited to one pair every 24 months.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's dental check-up	10% coinsurance	30% coinsurance	Coverage limited to 2 check-ups per person per calendar year. Coverage limited to $1,750 per individual per calendar year.

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.)

- Acupuncture
- Cosmetic Surgery
- Infertility Treatment
- Long-term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine Foot Care
- Weight Loss Program

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

- Bariatric Surgery (limited to $15,000 lifetime)
- Chiropractic Care (plan pays up to $20/visit; 30 visits per calendar year)
- Dental Care (Adult – see limits under Children's dental check-up on previous page)
- Hearing Aids (limited to $3,000 per 3 year period)
- Routine eye care (Adult - limited to 1 exam per calendar year)

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: Contact HealthComp at 1-800-442-7247 or 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 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: HealthComp at 1-800-442-7247 or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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 1-800-442-7247.

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** **$30**
- **Hospital (facility) copayment** **$150/day**
- **Other (test) 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	$0
Copayments	$300
Coinsurance	$100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$460**

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** **$30**
- **Hospital (facility) copayment** **$150/day**
- **Other (Brand drug) copayment** **$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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$10
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$730**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$30**
- **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	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$210**

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