




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 Personify Health (aka HealthComp) at 1-800-442-7247. 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 <https://www.healthcare.gov/sbc-glossary> or call 1-800-442-7247 to request a copy.

Important Questions	Answers		Why This Matters:
<p>What is the overall deductible?</p>	<p>Network Per Calendar Year \$6,350/Individual \$12,700/Family</p>	<p>Out-of-Network Per Calendar Year \$6,350/Individual \$6,350/Covered Person in a Family</p>	<p>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.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. Network only: Primary care and Specialists office visits, Online visits, Counseling office visits, Diagnostic tests – Laboratory services only, Preventive care, chiropractic care and Urgent care.</p>		<p>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/.</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>		<p>You don't have to meet deductibles for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>Network Per Calendar Year \$6,350/Individual \$12,700/Family</p>	<p>Out-of-Network Per Calendar Year \$12,700/Individual \$12,700/Covered Person in a Family</p>	<p>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.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Premiums, balance billing charges (unless balanced billing is prohibited), health care this plan doesn't cover, and cost containment penalties for failure to obtain precertification when required.</p>		<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider ?	Yes. See www.anthem.com/ca or call 1-800-442-7247 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 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	Visits 1-10 \$20/visit <hr/> Deductible waived Visits 11+ No charge	40% coinsurance	First 10 visits per Calendar Year are combined for the following: Network Primary care and Specialists office visits, Online visits, Counseling office visits, Chiropractic care and Urgent Care.
	Specialist visit	Visits 1-10 \$20/visit <hr/> Deductible waived Visits 11+ No charge	40% coinsurance	
	Preventive care/screening/immunization	No charge Deductible waived	40% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	Laboratory Services \$20/visit <hr/> Deductible waived X-ray No charge	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	40% coinsurance	Precertification may be required for certain services. If you don't get precertification, benefits could be reduced by 100%.

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 need drugs to treat your illness or condition More information about prescription drug coverage is available at www.anthem.com	Generic drugs	Retail & Mail order \$20/Prescription	Not covered	Retail is limited to a 30-day supply. Mail order is limited to a 90-day supply.
	Preferred brand drugs	Retail & Mail order \$40/Prescription	Not covered	
	Non-preferred brand drugs	Retail & Mail Order 50% coinsurance	Not covered	
	Specialty drugs	50% coinsurance	Not covered	Specially drugs must be obtained directly from the specialty pharmacy. Specialty drugs are not available at retail or mail order pharmacies. There are no grace fills provided to Covered Persons.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	40% coinsurance	Precertification may be required for certain services. If you don't get precertification, benefits could be reduced by 100%.
	Physician/surgeon fees	No charge	40% coinsurance	None

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 need immediate medical attention	Emergency room care	No charge		Out-of-Network non-emergent services in an emergency room are covered at 40% coinsurance .
	Emergency medical transportation	No charge		Out-of-Network non-emergent ground transports are covered at 40% coinsurance .
	Urgent care	Visits 1-10 \$20/visit <u>Deductible waived</u> Visits 11+ No charge	40% coinsurance	First 10 visits per Calendar Year are combined for the following: Network Primary care and Specialists office visits, Online visits, Counseling office visits, Chiropractic care and Urgent Care.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	40% coinsurance	Precertification is required. If you don't get precertification, benefits could be reduced by 100%.
	Physician/surgeon fees	No charge	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office \$20/visit <u>Deductible waived</u> Other services No charge	40% coinsurance	First 10 visits per Calendar Year are combined for the following: Network Primary care and Specialists office visits, Online visits, Counseling office visits, Chiropractic care and Urgent Care. Precertification may be required for facility services. If you don't get precertification, benefits could be reduced by 100%.
	Inpatient services	No charge	40% coinsurance	Precertification is required. If you don't get precertification, benefits could be reduced by 100%.

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 are pregnant	Office visits	No charge Deductible waived	40% coinsurance	Cost-sharing does not apply to certain preventive services . Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Precertification is only required for stays exceeding 48 hours after delivery (or 96 hours after C-section). If you don't get precertification when required, benefits could be reduced by 100%.
	Childbirth/delivery professional services	No charge	40% coinsurance	
	Childbirth/delivery facility services	No charge	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	40% coinsurance	None
	Rehabilitation services	No charge	40% coinsurance	None
	Habilitation services	No charge	40% coinsurance	None
	Skilled nursing care	No charge	40% coinsurance	Limited to 60 days per Calendar Year. Precertification is required. If you don't get precertification, benefits could be reduced by 100%
	Durable medical equipment	No charge	40% coinsurance	Precertification may be required for certain services. If you don't get precertification, benefits could be reduced by 100%.
	Hospice services	No charge	40% coinsurance	Precertification may be required for certain services. If you don't get precertification, benefits could be reduced by 100%.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Must enroll in separate vision plan .
	Children's glasses	Not covered	Not covered	Must enroll in separate vision plan .
	Children's dental check-up	Not covered	Not covered	Must enroll in separate dental plan .

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
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (Excluded except when related to treatment of Diabetes or Peripheral Vascular Disease)
- Weight loss programs

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

- Bariatric surgery (Limited to one surgery per lifetime)
- Chiropractic care. Copayments (\$20/visit, deductible waived) apply to the first 10 visits per calendar year combined for the following: Network Primary care and Specialists office visits, Online visits, Counseling office visits, Chiropractic care and Urgent 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: Personify Health (aka HealthComp) at 1-800-442-7247 or 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 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: Personify Health (aka HealthComp) at 1-800-442-7247 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

[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](#) \$6,350
- [Specialist coinsurance](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other (Tests) [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
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In this example Peg would pay:

Cost-Sharing	
Deductibles	\$6,000
Copayments	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$6,360

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$6,350
- [Specialist copays](#) \$20
- Hospital (facility) [coinsurance](#) 0%
- Other (Brand drugs) [copays](#) \$40

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
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In this example, Joe would pay:

Cost-Sharing	
Deductibles	\$10
Copayments	\$1,500
Coinsurance	0%
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,530

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$6,350
- [Specialist copays](#) \$20
- Hospital (ER) [coinsurance](#) 0%
- Other (Physical Therapy) [coinsurance](#) 0%

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
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In this example, Mia would pay:

Cost-Sharing	
Deductibles	\$2,500
Copayments	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
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.