



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, visit www.myhealthbenefits.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 www.healthcare.gov/sbc-glossary or call 1-844-277-8284 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$500/Individual or \$1,200/Family	Generally, you must pay all 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. Preventive care services, office visits, prescription drugs, and telemedicine visits.	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$5,000/Individual or \$10,000/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 , physician balance-billing charges, penalties for failure to obtain pre-authorization 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 ?	Provider Services: Yes. For a list of providers, visit www.anthem.com/ca .	Provider Services: 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 (lab work). Check with your provider before you get services.
	Facility Services: There is no network for facilities. Contact ClaimDOC at 1-888-330-7295 or visit portal.claim-doc.com for assistance with introducing the plan to your preferred facility or for assistance finding a facility (ER, outpatient, inpatient, imaging, and other facilities).	Facility Services: When your healthcare facilities submit your medical claims for processing, you are responsible for your patient responsibility (copay , deductible and coinsurance) as it appears on your Explanation of Benefits (EOB) that you receive from BRMS.
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) Facility Services: Open Access	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25/visit deductible waived	Not covered	Anthem Live Health Online: \$0/visit Telemedicine services provided by a primary care physician or specialist will be covered the same as any other office visit with that provider . 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.
	Specialist visit	\$35/visit deductible waived	Not covered	
	Preventive care/screening/immunization	No charge	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	Covered 100% after deductible	Not covered	None
	Imaging (CT/PET scans, MRIs)	Covered 100% after deductible		Some services may require preauthorization .

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
			Facility Services: Open Access	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.welldynrx.com or 1-888-479-2000	Generic drugs	Retail: \$10/prescription Mail: \$20/prescription	Not covered	Retail: Covers up to a 34-day supply. Mail Order: Covers 90-day supply. Mail Order Vendor: WellDyne Pharmacy.
	Preferred brand drugs	Retail: \$20/prescription Mail: \$40/prescription	Not covered	
	Non-preferred brand drugs	Retail: \$50/prescription Mail: \$100/prescription	Not covered	
	Specialty drugs	\$350/prescription	Not covered	Covers up to a 30-day supply. Specialty drugs must be obtained through WellDyne Specialty Pharmacy after one fill at a participating retail pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Covered 100% after deductible		Some procedures may require preauthorization .
	Physician/surgeon fees	Covered 100% after deductible		
If you need immediate medical attention	Emergency room care	\$500 copayment Covered at 100% after deductible		Inpatient services require preauthorization .
	Emergency medical transportation	Covered 100% after deductible	Covered 100% after deductible	You are responsible for balance billing if not a true emergency.
	Urgent care	\$50/visit deductible waived	Not covered	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) Facility Services: Open Access	
If you have a hospital stay	Facility fee (e.g., hospital room)	Covered 100% after deductible		Services require preauthorization .
	Physician/surgeon fees	Covered 100% after deductible		None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25/visit deductible waived	Not covered	None
	Inpatient services	Covered 100% after deductible		Services require preauthorization .
If you are pregnant	Office visits	\$25/visit deductible does not apply	Not covered	Cost sharing does not apply to preventive services .
	Childbirth/delivery professional services	Covered 100% after deductible	<u>Facility Based Professional Services:</u> Covered 100% after deductible	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Professional fees rendered in a facility setting are covered at 100% after deductible .
			<u>Laboratory/Office Based Professional Services:</u> Not covered	
	Childbirth/delivery facility services	Covered 100% after deductible		Preauthorization is required for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay.
If you need help recovering or have other special health needs	Home health care	Covered 100% after deductible	Not covered	Services require preauthorization .
	Rehabilitation services	Covered 100% after deductible		None
	Habilitation services	Covered 100% after deductible	Not covered	None
	Skilled nursing care	\$500 copayment after deductible		Must commence within 14 days of an inpatient hospital stay that is at least 3 days. Limited to 100 days per calendar year. Services require preauthorization .

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) Facility Services: Open Access	
If you need help recovering or have other special health needs	Durable medical equipment	Covered 100% after deductible	Not covered	None
	Hospice services	Covered 100% after deductible	<u>Facility Based Professional Services:</u> Covered 100% after deductible	Limited to 210 days per lifetime. Includes 15 family bereavement counseling sessions. Services require preauthorization .
			<u>Home Based Professional Services:</u> Not covered	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Refer to vision plan.
	Children's glasses	Not covered	Not covered	Refer to vision plan.
	Children's dental check-up	Not covered	Not covered	Refer to 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](#).)

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| <ul style="list-style-type: none"> • Acupuncture • Chiropractic Services • Cosmetic Surgery | <ul style="list-style-type: none"> • Hearing aids • Long term care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Routine eye care (Adult) • Routine foot care • Weight loss programs |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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| <ul style="list-style-type: none"> • Dental care (adult – accident only) • Bariatric (if medically necessary) | <ul style="list-style-type: none"> • Infertility treatment (\$5,000 lifetime maximum) | <ul style="list-style-type: none"> • Private duty nurse (in-network only) |
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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 the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and Benefit & Risk Management Services, Inc. (BRMS) at 1-844-277-8284. 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, Inc. (BRMS) at 1-844-277-8284.

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 1-844-277-8284.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-277-8284.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-277-8284.

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	\$500
■ Specialist copayment	\$35
■ Hospital (facility) copayment	\$0
■ Other (generic drug) copayment	\$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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$10
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$570

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$500
■ Specialist copayment	\$35
■ Hospital (facility) copayment	\$0
■ Other (brand drug) copay	\$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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$700
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$720

Mia's Simple Fracture

(emergency room visit and follow up care)

■ The plan's overall deductible	\$500
■ Specialist copayment	\$35
■ Hospital (facility) copayment	\$0
■ Other (generic drug) copayment	\$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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$100
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$600