




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, contact 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 <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 <a href="#">deductible</a> ?	<b><a href="#">Network Provider</a></b> <i>Per Plan Year</i>  \$500/Individual \$1,500/Family	<b><a href="#">Out-of-Network Provider</a></b> <i>Per Plan Year</i>  \$1,000/Individual \$3,000/Family	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Urgent care, diabetes education, qualified travel expenses for Bariatric, Sex Change and Organ transplant surgeries; NETWORK: <a href="#">Preventive care</a> , Office visits, Hospice, LiveHealth Online Services are covered before you meet your <a href="#">deductible</a> .		This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.		You don't have to meet <a href="#">deductibles</a> for specific services.

Important Questions	Answers		Why This Matters:
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<a href="#">Network Provider</a> Per Plan Year  \$3,400/Individual \$6,800/two party \$10,000/Family	<a href="#">Out-of-Network Provider</a> Per Plan Year  \$8,400/Individual \$16,800/two party \$26,800/Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
	<a href="#">Prescription Drugs</a> Per Plan Year  \$1,600/Individual \$3,200/Family		
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, utilization management penalties and health care this <a href="#">plan</a> doesn't cover.		Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="#">www.anthem.com/ca</a> or call 1-800-442-7247 for a list of <a href="#">network providers</a> .		This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.		You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$30/visit <a href="#">Deductible</a> waived	\$50/visit <a href="#">Deductible</a> waived	<a href="#">Copay</a> applies to office visit charges only. Additional services billed at the time of the visit may be subject to <a href="#">deductible</a> and applicable <a href="#">coinsurance</a> .
	<a href="#">Specialist</a> visit	\$40/visit <a href="#">Deductible</a> waived	\$60/visit <a href="#">Deductible</a> waived	<a href="#">Copay</a> applies to office visit charges only. Additional services billed at the time of the visit may be subject to <a href="#">deductible</a> and applicable <a href="#">coinsurance</a> .
	<a href="#">Preventive care/screening/immunization</a>	No charge <a href="#">Deductible</a> waived	30% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for. As defined by the Patient Protection and Affordable Care Act.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Out-of-Network</a> maximum \$800 per procedure. <a href="#">Precertification</a> may be required.

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)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="http://www.express-scripts.com">prescription drug coverage</a> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a>	Generic drugs	<b>Retail</b> \$15/prescription <hr/> <b>Mail order/90-Day Retail</b> \$23/prescription	<b>Retail</b> \$15/prescription <hr/> <b>Mail order/90-Day Retail</b> Not Covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (Mail Order or Retail 90 Maintenance prescriptions).  Retail not available for <a href="#">Specialty drugs</a> (Tier 4), and limited to a 30 day supply.  <a href="#">Out-of-Network</a> Retail pharmacies <a href="#">copay</a> plus all charges in excess of allowable charge.
	Preferred brand drugs	<b>Retail</b> \$35/prescription <hr/> <b>Mail order/90-Day Retail</b> \$53/prescription	<b>Retail</b> \$35/prescription <hr/> <b>Mail order/90-Day Retail</b> Not Covered	
	Non-preferred brand drugs	<b>Retail</b> \$50/prescription <hr/> <b>Mail order/90-Day Retail</b> \$75/prescription	<b>Retail</b> \$50/prescription <hr/> <b>Mail order/90-Day Retail</b> Not Covered	
	<a href="#">Specialty drugs</a>	<b>Retail</b> Not available <hr/> <b>Mail order</b> \$150/prescription	<b>Retail &amp; Mail order</b> Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Precertification</a> is required. If you don't get <a href="#">precertification</a> , benefits could be reduced. <a href="#">Out-of-network</a> maximum \$350 per admit.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$150/visit + 20% <a href="#">coinsurance</a>		<a href="#">Copay</a> waived if admitted. <a href="#">Copay</a> applies to facility charge only; emergency room physician may be separate charge.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>		None
	<a href="#">Urgent care</a>	\$30/visit <a href="#">Deductible</a> waived		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 have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Precertification</a> is required for inpatient services; waived for emergency admissions. Failure to obtain <a href="#">precertification</a> will result in a \$500 penalty for Non-Anthem Blue Cross PPO hospitals or residential treatment centers.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	<b>Office</b> \$30/visit <a href="#">Deductible</a> waived <hr/> <b>Other</b> 20% <a href="#">coinsurance</a>	<b>Office</b> \$50/visit <a href="#">Deductible</a> waived <hr/> <b>Other</b> 30% <a href="#">coinsurance</a>	None
	Inpatient services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Precertification</a> is required for inpatient services; waived for emergency admissions. Failure to obtain <a href="#">precertification</a> will result in a \$500 penalty for Non-Anthem Blue Cross PPO hospitals or residential treatment centers.
If you are pregnant	Office visits	No charge <a href="#">Deductible</a> waived	\$50/visit <a href="#">Deductible</a> waived	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Precertification</a> is only required for stay exceeding 48 hours after delivery (or 96 hours after C-section.).

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 help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Limited to 100 visits per Plan Year. <a href="#">Precertification</a> is required. If you don't get a <a href="#">precertification</a> , benefits could be reduced.
	<a href="#">Rehabilitation services</a>	Physical, Speech, Occupational Therapies and Chiropractic care 20% <a href="#">coinsurance</a>	Physical, Speech, Occupational Therapies and Chiropractic care 30% <a href="#">coinsurance</a>	Limited to 24 visits per Plan Year combined for chiropractic care, physical therapy and occupational therapy. Additional visits allowed for physical and occupational therapies if medically necessary.
	<a href="#">Habilitation services</a>			All rehabilitative and habilitative visits count toward your rehabilitation visit limit where applicable. Limits for habilitation services do not apply to autism spectrum disorders.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Limited to 100 visits per Plan Year. <a href="#">Precertification</a> is required. If you don't get a <a href="#">precertification</a> , benefits could be reduced.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Precertification</a> may be required.
	<a href="#">Hospice services</a>	No charge <a href="#">Deductible</a> waived	30% <a href="#">coinsurance</a>	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Must enroll in separate vision <a href="#">plan</a> for benefits
	Children's glasses	Not covered	Not covered	Must enroll in separate vision <a href="#">plan</a> for benefits
	Children's dental check-up	Not covered	Not covered	Must enroll in separate dental <a href="#">plan</a> for benefits

## 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      | • Long Term Care                                     | • Routine Eye Care (Adult) |
| • Dental Care (Adult)   | • Non-emergency care when traveling outside the U.S. | • Routine Foot Care        |
| • Infertility Treatment | • Private Duty Nursing                               | • Weight Loss Programs     |

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

- |  |  |  |
|--|--|--|
| • Acupuncture (Limited to 12 visits per Plan Year) | • Bariatric Surgery                                      | • Hearing Aids (\$2,500 maximum pre ear every 36 months) |
|  | • Chiropractic Care (Limited to 24 visits per Plan 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: (for ERISA Plans): Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](http://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 Administrators 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](http://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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other (Tests) <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$2,400
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,970</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other (Brand drugs) <a href="#">copayment</a>	\$35

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$1,400
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,520</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital(ER) <a href="#">copay+coinsurance</a>	\$150+20%
■ Other (Physical Therapy) <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$300
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,100</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.