




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:
<b>What is the overall <a href="#">deductible</a>?</b>	<a href="#">Network</a> \$75/Individual \$150/Family	<a href="#">Out-of-Network</a> \$150/Individual \$300/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> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> , physician's office visits, emergency room, ambulance, acupuncture, hearing exam, and medication management 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> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.		You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<a href="#">Network</a> \$475/Individual \$950/Family	<a href="#">Out-of-Network</a> \$950/Individual \$1,900/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.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, 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> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.anthem.com/ca">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	\$10/visit <a href="#">Deductible</a> waived	40% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$10/visit <a href="#">Deductible</a> waived	40% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge <a href="#">Deductible</a> waived	40% <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
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	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)	
<p><b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.anthem.com/ca">www.anthem.com/ca</a></p>	Generic drugs	<b>Retail</b> \$5/prescription <hr/> <b>Mail order</b> \$10/prescription	Not covered	<p>Covers up to a 31-day supply (retail prescription); 31-90 day supply (mail order prescription or other 90 day retail).</p> <p>Should the Covered Person request a brand name drug when the generic is available, and the Physician has NOT provided evidence of medical necessity, the Covered Person will be liable for the difference between the brand name and the generic in addition to the brand name <a href="#">Copay</a>.</p>
	Preferred brand drugs	<b>Retail</b> 25% coinsurance up to \$35/prescription <hr/> <b>Mail order &amp; retail 90</b> \$50/prescription	Not covered	
	Non-preferred brand drugs	<b>Retail</b> 45% coinsurance up to \$70/prescription <hr/> <b>Mail order &amp; Retail 90</b> \$90/prescription	Not covered	
	<a href="#">Specialty drugs</a>	<b>IngenioRx Cost Relief Program – No charge</b> <b>Unavailable through the IngenioRx Cost Relief Program:</b> Preferred Brand – 25% <a href="#">coinsurance</a> up to \$35/prescription Non-Preferred Brand – 45% <a href="#">coinsurance</a> up to \$70/prescription <hr/> <b>Voluntary opt out of IngenioRx Cost Relief Program:</b> Preferred Brand – 30% <a href="#">coinsurance</a> /prescription Non-Preferred Brand – 45% <a href="#">coinsurance</a> / prescription	Not applicable	<p>Covers up to a 30-day supply.</p> <p>Specialty Drugs are only available from the Specialty Pharmacy and you will not be able to obtain them at a Retail Pharmacy or through the Home Delivery (Mail Order) Pharmacy. Your medication may be available through the IngenioRX Cost Relief program. The list of prescription drugs covered by the IngenioRX Cost Relief Program may be updated periodically by the Plan. For additional information contact IngenioRX at 877-638-4008. If you are eligible for the IngenioRX Cost Relief Program and choose to opt out, you will be subject to the Specialty Drug <a href="#">Coinsurance</a>.</p>

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Precertification</a> is required. If you don't get <a href="#">precertification</a> , benefits could be reduced.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$50/visit + 20% <a href="#">coinsurance</a> <a href="#">Deductible</a> waived		<a href="#">Copay</a> waived if admitted
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a> <a href="#">Deductible</a> waived		<a href="#">Out-of-Network</a> : Non-emergent transportation is 40% <a href="#">coinsurance</a>
	<a href="#">Urgent care</a>	<b>Office</b> \$10/visit <a href="#">Deductible</a> waived <hr/> <b>Other</b> 20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Precertification</a> is required. If you don't get <a href="#">precertification</a> , benefits could be reduced.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	<b>Office</b> \$10/visit <a href="#">Deductible</a> waived <hr/> <b>Other</b> 20% <a href="#">coinsurance</a>	<b>Office</b> 40% <a href="#">coinsurance</a> <hr/> <b>Other</b> 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)	
If you need mental health, behavioral health, or substance abuse services	Inpatient services	20% <a href="#">coinsurance</a>	Not covered	Limited to 100 days per Calendar Year mental health and substance abuse combined. Inpatient, partial hospitalization, & residential treatment combined. <a href="#">Precertification</a> is required. If you don't get <a href="#">precertification</a> , benefits could be reduced.
If you are pregnant	Office visits	\$10/visit <a href="#">Deductible</a> waived	40% <a href="#">coinsurance</a>	<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>	40% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Precertification</a> is only required for stay exceeding 48 hours after delivery (or 96 hours after C-section).
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Limited to 100 visits per Calendar 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>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Limited to 1 visit per day for Occupational, and Physical Therapy/each.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Limited to 20 visits per Calendar Year. Not covered for autism spectrum disorders.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Limited to 100 days per Calendar Year. <a href="#">Precertification</a> is required. If you don't get a <a href="#">precertification</a> , benefits could 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)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Precertification</a> is required for billed charges in excess of \$2,000. If you don't get a <a href="#">precertification</a> , benefits could be reduced.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Bereavement: Limited to 4 visits per Calendar Year. \$25 per visit maximum paid.
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> .
	Children's glasses	Not covered	Not covered	Must enroll in separate vision <a href="#">plan</a> .
	Children's dental check-up	Not covered	Not covered	Must enroll in separate dental <a href="#">plan</a> .

### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Bariatric Surgery</li> <li>Dental Care (Adult)</li> <li>Hearing Aids</li> <li>Infertility Treatment</li> </ul>	<ul style="list-style-type: none"> <li>Long Term Care</li> <li>Non-emergency care when traveling outside the U.S.</li> <li>Private Duty Nursing</li> </ul>	<ul style="list-style-type: none"> <li>Routine Eye Care (Adult)</li> <li>Routine Foot Care</li> <li>Weight Loss Programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>Acupuncture</li> </ul>	<ul style="list-style-type: none"> <li>Chiropractic Care (Limited to 1 visit per day and 12 visits per Calendar Year)</li> </ul>	<ul style="list-style-type: none"> <li>Cosmetic Surgery (Limited)</li> </ul>

**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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://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](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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://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](#) \$75
- [Specialist copayment](#) \$10
- Hospital (facility) [coinsurance](#) 20%
- Other (Tests) [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*)

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

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$75
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$535</b>

**Managing Joe's Type 2 Diabetes**

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

- The [plan's](#) overall [deductible](#) \$75
- [Specialist copayment](#) \$10
- Hospital (facility) [coinsurance](#) 20%
- Other (Brand drugs) [copayment](#) \$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:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$75
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$10
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$495</b>

**Mia's Simple Fracture**

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

- The [plan's](#) overall [deductible](#) \$75
- [Specialist copayment](#) \$10
- Hospital (ER) [copay+coinsurance](#) \$50+20%
- Other (Physical Therapy) [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*)

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

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$75
<a href="#">Copayments</a>	\$80
<a href="#">Coinsurance</a>	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$475</b>

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