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 deductible?	**Network** $500/Individual $1,000/Family	**Out-of-Network** $1,000/Individual $2,000/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. Preventive care, physicians office visits, emergency room, ambulance, acupuncture, hearing exam, and medication management are covered before you meet your deductible.		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/.
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?	**Network** $2,500/Individual $5,000/Family	**Out-of-Network** $5,000/Individual $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.
	Prescription Drug $1,000/Individual $2,000/Family		
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.		Even though you pay these expenses, they don't count toward the out–of–pocket limit.

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	$15/visit Deductible waived	30% coinsurance	None
	Specialist visit	$15/visit Deductible waived	30% coinsurance	None
	Preventive care/screening/ immunization	No charge Deductible waived	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need 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

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/ca	Generic drugs	**Retail** $5/prescription **Mail order** $10/prescription	Not covered	Covers up to a 31-day supply (retail prescription); 31-90 day supply (mail order prescription or other 90 day retail). 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 Copay.
	Preferred brand drugs	**Retail** 25% coinsurance up to $35/prescription **Mail order & Retail 90** $50/prescription	Not covered	
	Non-preferred brand drugs	**Retail** 45% coinsurance up to $70/prescription **Mail order & Retail 90** $90/prescription	Not covered	
	Specialty drugs	**IngenioRx Cost Relief Program** – No charge **Unavailable through the IngenioRx Cost Relief Program**: Preferred Brand – 25% coinsurance up to $35/prescription Non-Preferred Brand – 45% coinsurance up to $70/prescription **Voluntary opt out of IngenioRx Cost Relief Program:** Preferred Brand – 30% coinsurance /prescription Non-Preferred Brand – 45% coinsurance/ prescription	Not applicable	Covers up to a 30-day supply. 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 Coinsurance.

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)	10% coinsurance	30% coinsurance	Precertification is required. If you don't get precertification, benefits could be reduced.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$50/visit + 10% coinsurance Deductible waived		Copay waived if admitted
	Emergency medical transportation	10% coinsurance Deductible waived		Out-of-Network: Non-emergent transportation is 30% coinsurance
	Urgent care	**Office** $15/visit Deductible waived **Other** 10% coinsurance	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Precertification is required. If you don't get precertification, benefits could be reduced.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Office** $15/visit Deductible waived **Other** 10% coinsurance	**Office** 30% coinsurance **Other** 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	10% coinsurance	Not covered	Limited to 100 days per Calendar Year mental health and substance abuse combined. Inpatient, partial hospitalization, & residential treatment combined. Precertification is required. If you don't get precertification, benefits could be reduced.
If you are pregnant	Office visits	$15/visit Deductible waived	30% 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).
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	Precertification 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	Home health care	10% coinsurance	30% coinsurance	Limited to 100 visits per Calendar Year. Precertification is required. If you don't get a precertification, benefits could be reduced.
	Rehabilitation services	10% coinsurance	30% coinsurance	Limited to 1 visit per day for Occupational, and Physical Therapy/each.
	Habilitation services	10% coinsurance	30% coinsurance	Limited to 20 visits per Calendar Year. Not covered for autism spectrum disorders.
	Skilled nursing care	10% coinsurance	30% coinsurance	Limited to 100 days per Calendar Year. Precertification is required. If you don't get a precertification, 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	Durable medical equipment	10% coinsurance	30% coinsurance	Precertification is required for billed charges in excess of $2,000. If you don't get a precertification, benefits could be reduced.
	Hospice services	10% coinsurance	30% coinsurance	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 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.)

- Bariatric 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
- Weight Loss Programs

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

- Acupuncture
- Chiropractic Care (Limited to 1 visit per day and 12 visits per Calendar Year)
- Cosmetic Surgery (Limited)

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. 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 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.

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** **$500**
- **Specialist copayment** **$15**
- **Hospital (facility) coinsurance** **10%**
- **Other (Tests) 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	$500
Copayments	$10
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,770**

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** **$15**
- **Hospital (facility) coinsurance** **10%**
- **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)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$100
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,320**

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

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$15**
- **Hospital (ER) copay+coinsurance** **$50+10%**
- **Other (Physical Therapy) coinsurance** **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**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$100
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

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