




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> ?	<a href="#">Network Provider</a> \$250/Individual \$750/Family	<a href="#">Out-of-Network Provider</a> Not Applicable	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. <a href="#">Preventive care</a> , Urgent care, Office visits, Hospice, LiveHealth Online Services, diabetes education, qualified travel expenses for Bariatric, Sex Change and Organ transplant surgeries 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.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<a href="#">Network Provider</a> \$3,400/Individual \$6,800/two party \$10,000/Family	<a href="#">Out-of-Network Provider</a> Not Applicable	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>Prescription Drug</b> \$1,600/Individual \$3,200/Family <a href="#">Out-of-Network</a> is unlimited		
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> .

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 office</a> or clinic	Primary care visit to treat an injury or illness	\$25/visit <a href="#">Deductible</a> waived	Not covered	<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	\$35/visit <a href="#">Deductible</a> waived	Not covered	<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	Not covered	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)	\$10/day	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$50/day	Not covered	<a href="#">Precertification</a> is required. If you don't get <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)	
<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.express-scripts.com">www.express-scripts.com</a>	Generic drugs	<b>Retail</b> \$10/prescription <hr/> <b>Mail order/90-Day Retail</b> \$15/prescription	<b>Retail</b> \$10/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> \$25/prescription <hr/> <b>Mail order/90-Day Retail</b> \$38/prescription	<b>Retail</b> \$25/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)	No charge	Not covered	<a href="#">Precertification</a> is required. If you don't get <a href="#">precertification</a> , benefits could be reduced.
	Physician/surgeon fees	No charge	Not covered	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$150/visit		<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>	No charge		None
	<a href="#">Urgent care</a>	\$25/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)	No charge	Not covered	<a href="#">Precertification</a> is required. If you don't get <a href="#">precertification</a> benefits may be reduced; waived for emergency admissions.
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	<b>Office</b> \$25/visit <a href="#">Deductible</a> waived <hr/> <b>Other</b> No charge	Not covered	None
	Inpatient services	No charge	Not covered	<a href="#">Precertification</a> is required. If you don't get <a href="#">precertification</a> benefits may be reduced; waived for emergency admissions.
If you are pregnant	Office visits	<b>Prenatal</b> No charge <a href="#">Deductible</a> waived <hr/> <b>Postnatal</b> \$25/visit <a href="#">Deductible</a> waived	Not covered	<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	No charge	Not covered	
	Childbirth/delivery facility services	No charge	Not covered	<a href="#">Preauthorization</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>	No charge	Not covered	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 No charge	Not covered	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>			
	<a href="#">Skilled nursing care</a>	No charge	Not covered	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>	No charge	Not covered	<a href="#">Precertification</a> is required. If you don't get <a href="#">precertification</a> , benefits could be reduced.
	<a href="#">Hospice services</a>	No charge <a href="#">Deductible</a> waived	Not covered	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
- Dental Care (Adult)
- 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 (if prescribed for rehabilitation purposes)
- Bariatric Surgery (\$3,000 maximum per surgery)
- Chiropractic Care (Limited to 24 visits per Plan Year)
- Hearing Aids (\$2,500 maximum per ear every 36 months)

**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>	\$250
■ <a href="#">Specialist copayment</a>	\$35
■ Hospital (facility) <a href="#">copayment</a>	\$0
■ Other (Tests) <a href="#">copayment</a>	\$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*)

<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>	\$250
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$510</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>	\$250
■ <a href="#">Specialist copayment</a>	\$35
■ Hospital (facility) <a href="#">copayment</a>	\$0
■ Other (Brand drugs) <a href="#">copayment</a>	\$25

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>	\$100
<a href="#">Copayments</a>	\$1,200
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,320</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>	\$250
■ <a href="#">Specialist copayment</a>	\$35
■ Hospital (ER) <a href="#">copayment</a>	\$150
■ Other (Physical Therapy) <a href="#">copayment</a>	\$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*)

<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>	\$250
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$650</b>

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