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 Provider** $1,750/Self only **Family Coverage** $3,500/Family	**Non-Network Provider** $1,750/Self only **Family Coverage** $3,500/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 policy, the overall family deductible must be met before the plan begins to pay
	Amounts applied toward Network deductible also apply toward Non-Network deductible and vice versa		
Are there services covered before you meet your deductible?	Yes. Preventive care services 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 Provider** $3,500/Self-only **Family coverage** $3,500/Individual $7,000/Family	**Non-Network Providers** $6,000/Self-only **Family coverage** $6,000/Individual $12,000/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, 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? **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 Non-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 Non-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)	Non-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	10% coinsurance	40% coinsurance	None
	Specialist visit	10% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No charge Deductible waived	40% coinsurance	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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	40% coinsurance	$800 maximum payment per procedure for Non-Network Providers when done in an outpatient setting. Precertification may be required for certain services. If you don't get precertification, benefits could be reduced.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.southernscripts.net	Generic drugs	**Retail** $15/prescription **Mail order** $30/prescription	Not covered	Covers up to a 30-day supply at Non-First Choice retail pharmacy; up to 90 day supply at First Choice retail pharmacies and mail order. If you are eligible to receive a subsidy through a manufacturer copay program, your copayment under the Variable Copay™ Program will be equal to the maximum subsidy available through that manufacturer copay program. Any manufacturer copay subsidy obtained under the Variable Copay™ Program will not accumulate toward your deductible or out of pocket costs. If you choose to enroll in the Manufacturer Free Drug Initiative and receive a drug through a manufacturer free drug program, that drug will not be covered under the plan and you will have no cost sharing under this plan for that drug.
	Preferred brand drugs	**Retail** $30/prescription **Mail order** $60/prescription	Not covered	
	Non-preferred brand drugs	**Retail** $45/prescription **Mail order** $90/prescription	Not covered	
	Specialty drugs	**Retail or Mail order** 30% coinsurance up to a $200 maximum per prescription	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	$350 maximum payment per procedure for Non-Network Providers. Precertification may be required for certain services. If you don't get precertification, benefits could be reduced.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	None
	Emergency medical transportation	10% coinsurance	10% coinsurance	Non-emergent Air Ambulance: $50,000 maximum payment by plan per trip.
	Urgent care	10% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	Precertification is required. If you don't get precertification, benefits could be reduced by $500. Limited to $1,000 maximum payment per day for Non-Network Providers.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	40% coinsurance	Precertification may be required for certain services. If you don't get precertification, benefits could be reduced.
	Inpatient services	10% coinsurance	40% coinsurance	Precertification is required. If you don't get precertification, benefits could be reduced by $500. Limited to $1,000 maximum payment per day for Non-Network Providers.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge Deductible waived	40% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	40% coinsurance	Limited to $1,000 maximum payment per day for Non-Network Providers. Precertification is only required for stay exceeding 48 hours after delivery (or 96 hours after C-section.) When precertification is required and is not obtained, benefit could be reduced by $500.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	40% coinsurance	Limited to 100 visits per calendar year. Precertification is required. If you don't get precertification, benefits could be reduced.
	Rehabilitation services	10% coinsurance	40% coinsurance	$1,000 maximum payment by plan per day for inpatient Non-Network Providers. Precertification is required for inpatient care. If you don't get precertification, benefits could be reduced.
	Habilitation services	10% coinsurance	40% coinsurance	None
	Skilled nursing care	10% coinsurance	40% coinsurance	Limited to 100 days per calendar year. Precertification is required. If you don't get precertification, benefits could be reduced by $500. SNF Rehab $1,000 maximum payment per day for Non-Network Providers.
	Durable medical equipment	50% coinsurance	50% coinsurance	Precertification may be required for certain services. If you don't get precertification, benefits could be reduced.
	Hospice services	10% coinsurance	40% 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)	Non-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Must enroll in separate vision plan for vision benefits.
	Children's glasses	Not covered	Not covered	Must enroll in separate vision plan for vision benefits.
	Children's dental check-up	Not covered	Not covered	Must enroll in separate dental plan for dental 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 Care
- Dental Care (Adult)
- Infertility Treatment
- Hearing Aids
- 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 (Limited to 30 visits per calendar year maximum)
- Bariatric Surgery (Must be performed at a Blue Distinction facility)
- Chiropractic Care (Limited to 30 visits per calendar year maximum)

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: HealthComp LLC at 1-800-442-7247 Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 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.

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	**$1,750**
Specialist coinsurance	**10%**
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	$1,750
Copayments	$100
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,010**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$1,750**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other (Brand drugs) copayment	**$30**

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	$1,200
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,220**

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

The plan's overall deductible	**$1,750**
Specialist coinsurance	**10%**
Hospital (ER) coinsurance	**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	$1,750
Copayments	$100
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,050**

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