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** *Per Plan Year* $1,500/Self only **Family coverage** $3,000/Individual $3,000/Family	**Out-of-Network Provider** *Per Plan Year* $1,500/Self only **Family coverage** $3,000/Individual $3,000/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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible, when rendered by a Network Provider.		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** *Per Plan Year* $5,000/Self only **Family coverage** $5,000/Individual $10,000/Family	**Out-of-Network Provider** *Per Plan Year* $5,000/Self only **Family coverage** $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.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, utilization management penalties and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
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	10% coinsurance	30% coinsurance	None
	Specialist visit	10% coinsurance	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. As defined by the Patient Protection and Affordable Care Act.

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 test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Out-of-Network maximum $800 per procedure. Precertification may be required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.express-scripts.com**	Generic drugs	**Retail** $10/prescription **Mail order/90-Day Retail** $20/prescription	**Retail** $10/prescription **Mail order/90-Day Retail** 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 Specialty drugs (Tier 4), and limited to a 30 day supply. Out-of-Network Retail pharmacies copay plus all charges in excess of allowable charge.
	Preferred brand drugs	**Retail** $25/prescription **Mail order/90-Day Retail** $50/prescription	**Retail** $25/prescription **Mail order/90-Day Retail** Not Covered	
	Non-preferred brand drugs	**Retail** $50/prescription **Mail order/90-Day Retail** $100/prescription	**Retail** $50/prescription **Mail order/90-Day Retail** Not Covered	
	Specialty drugs	**Retail** Not available **Mail order** 20% coinsurance	**Retail & Mail order** 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)	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. Out-of-network maximum $350 per admit.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance		Copay waived if admitted. Copay applies to facility charge only; emergency room physician may be separate charge.
	Emergency medical transportation	10% coinsurance		None
	Urgent care	10% 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 may be reduced;
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	Precertification is required for inpatient services; waived for emergency admissions.
	Inpatient services	10% coinsurance	30% 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 are pregnant	Office visits	No charge 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 Plan Year. Precertification is required. If you don't get a precertification, benefits could be reduced.
	Rehabilitation services	**Physical, Speech, Occupational Therapies and Chiropractic care** 10% coinsurance	**Physical, Speech, Occupational Therapies and Chiropractic care** 30% coinsurance	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. Limits for habilitation services do not apply to autism spectrum disorders.
	Habilitation services			
	Skilled nursing care	10% coinsurance	30% coinsurance	Limited to 100 visits per Plan Year. Precertification is required. If you don't get a precertification, benefits could be reduced.
	Durable medical equipment	10% coinsurance	30% coinsurance	Precertification is required. If you don't get precertification, benefits could be reduced.
	Hospice services	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 your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Must enroll in separate vision plan for benefits
	Children's glasses	Not covered	Not covered	Must enroll in separate vision plan for benefits
	Children's dental check-up	Not covered	Not covered	Must enroll in separate dental plan 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 (Limited to 12 visits per Plan year)
- Bariatric 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. 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	**$1,500**
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	$1,500
Copayments	$10
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,670**

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

The plan's overall deductible	**$1,500**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other (Brand drugs) copayment	**$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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$800
Coinsurance	$50
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,370**

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

The plan's overall deductible	**$1,500**
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	$1,500
Copayments	$10
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,610**

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