




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 Personify Health (aka 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 ?	\$0	See the Common Medical Events chart below for your costs for services this plan covers.																
Are there services covered before you meet your deductible ?	Yes. All covered services	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 ?	<table border="1"> <thead> <tr> <th colspan="2"><u>Medical</u></th> </tr> <tr> <th>Network Providers</th> <th>Out-of-Network Providers</th> </tr> <tr> <td><i>Per Calendar Year</i></td> <td><i>Per Calendar Year</i></td> </tr> </thead> <tbody> <tr> <td>\$1,500/Individual</td> <td>\$15,000/Individual</td> </tr> <tr> <td>\$3,000/Family</td> <td>Unlimited/Family</td> </tr> <tr> <th colspan="2"><u>Prescription Drug</u></th> </tr> <tr> <td>\$1,500/Individual</td> <td>\$15,000/Individual</td> </tr> <tr> <td>\$3,000/Family</td> <td>Unlimited/Family</td> </tr> </tbody> </table>	<u>Medical</u>		Network Providers	Out-of-Network Providers	<i>Per Calendar Year</i>	<i>Per Calendar Year</i>	\$1,500/Individual	\$15,000/Individual	\$3,000/Family	Unlimited/Family	<u>Prescription Drug</u>		\$1,500/Individual	\$15,000/Individual	\$3,000/Family	Unlimited/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.
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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 1-800-274-7767 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	\$30/visit	\$65/visit	None
	Specialist visit	\$30 /visit	\$65/visit	None
	Preventive care/screening/immunization	No charge	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.

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)	No charge	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	30% coinsurance	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 LucyRx at 1-877-860-8846	Generic drugs	Retail \$10/prescription <hr/> Mail Order \$10/prescription	Retail \$10/prescription + balance bill <hr/> Mail Order \$10/prescription + balance bill	Retail is limited to a 90-day supply. Mail order is limited to a 90-day supply. Precertification is required on select medications; Formulary drug list.
	Preferred brand drugs	Retail \$35/prescription <hr/> Mail Order \$35/prescription	Retail \$35/prescription + balance bill <hr/> Mail Order \$35/prescription + balance bill	
	Non-preferred brand drugs	Retail \$45/prescription <hr/> Mail Order \$45/prescription	Retail \$45/prescription <hr/> Mail Order \$45/prescription + balance bill	
	Specialty drugs	\$10/\$35/\$45/prescription	30% coinsurance	Up to a 30-day supply Precertification is required.

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)	No charge	30% coinsurance	Precertification may be required for certain services. If you don't get precertification, benefits could be reduced.
	Physician/surgeon fees	No charge	30% coinsurance	
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	None
	Emergency medical transportation	\$100/trip	\$100/trip	None
	Urgent care	10% coinsurance	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% coinsurance	Precertification is required. If you don't get precertification, benefits could be reduced.
	Physician/surgeon fees	No charge	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office \$30/visit Other No charge	Office \$65/visit Other 30% coinsurance	Precertification may be required for facility services. If you don't get precertification, benefits could be reduced.
	Inpatient services	No charge	30% coinsurance	Precertification is required. If you don't get precertification, benefits could be reduced.
If you are pregnant	Office visits	No charge	Not covered	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). Dependent daughters are not covered.
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	No charge	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 need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	None
	Rehabilitation services	10% coinsurance	30% coinsurance	Includes Physical, Speech, and Occupational Therapies.
	Habilitation services	10% coinsurance	30% coinsurance	None
	Skilled nursing care	10% coinsurance	30% coinsurance	Within 7 days of a 3 day hospital stay, up to 90 days per Calendar Year. Precertification is required. If you don't get precertification, benefits may be reduced.
	Durable medical equipment	10% coinsurance	30% coinsurance	Precertification may be required for certain services. If you don't get precertification, benefits could be reduced.
	Hospice services	No charge	30% coinsurance	Limited to 180 Lifetime maximum. Precertification may be required for certain services. If you don't get precertification, benefits could be reduced.
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)
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- 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 25 visits per Calendar Year)
- Bariatric Surgery
- Chiropractic Care (Limited to 25 visits per Calendar Year)
- Private Duty Nursing

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: Personify Health (aka HealthComp) 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. 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: Personify Health (aka HealthComp) 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	\$0
■ Specialist copayment	\$35
■ Hospital (facility) copayment	\$0
■ Other (Tests) copayment	\$0

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$560

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$35
■ Hospital (facility) copayment	\$0
■ 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,420

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$35
■ 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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$300
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$400

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