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 The Benefits Department at 1-844-814-3437. 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 www.dol.gov/ebsa/healthreform.

Important Questions	Answers		Why This Matters:
What is the overall deductible?	In-Network: $1,500 Individual $3,000 Family	Out-of-Network: $5,000 Individual $10,000 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.
	Per Calendar Year		
Are there services covered before you meet your deductible?	Yes. Preventive care, primary care, physician, office visits & specialist office visits, urgent care.		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?	Yes. Prescription drug coverage has a $350 deductible (does not apply to Tier 1 drugs).		You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-Network: $6,000 Individual $12,000 Family	Out-of-Network: $12,000 Individual $24,000 Family	The out-of-pocket limit is the most you could pay during the calendar 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.
	Per Calendar Year		
What is not included in the out-of-pocket limit?	Penalties for failing to follow precertification, amounts in excess of UCR, 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 for a list of network providers, or call 1-800-274-7767.	The 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 obtain services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.

 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
		In-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	$50/visit	50% coinsurance	None.
	Specialist visit	$50/visit	50% coinsurance	None.
	Preventive care/screening/ immunization	No Charge	50% coinsurance	As required under the Patient Protection and Affordable Care Act, US Preventive Services Task Force: www.uspreventiveservicestaskforce.org. 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.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	Precertification is required. If you don't obtain precertification when required, a non-compliance penalty, per occurrence, will be assessed.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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.magellanrx.com or 1-800-424-3312.**	Generic drugs (Tier 1)	Retail/Mail Order: $20/prescription Deductible waived	Retail: 50% coinsurance Mail Order: Not Covered	None.
	Preferred brand drugs (Tier 2)	Retail: $50/prescription Mail Order: $100/prescription	Retail: 50% coinsurance Mail Order: Not Covered	Pharmacy Deductible: $350/individual (applies to Tiers 2, 3, 4) Retail: covers up to a 30-day supply Mail Order: covers 31 – 90 days supply
	Non-preferred brand drugs (Tier 3)	Retail: $75/prescription Mail Order: $150/prescription	Retail: 50% coinsurance Mail Order: Not Covered	
	Specialty drugs (Tier 4)	Retail: 30% coinsurance up to $200 Mail Order: 30% coinsurance up to $400	Retail: 50% coinsurance Mail Order: Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	Precertification is required. If you don't obtain precertification when required, a non-compliance penalty, per occurrence, will be assessed.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	30% coinsurance		In-Network Deductible applies to Out-of-Network benefits.
	Emergency medical transportation	30% coinsurance		In-Network Deductible applies to Out-of-Network benefits.
	Urgent care	$50/visit	50% coinsurance	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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)	30% coinsurance	50% coinsurance	Precertification is required. If you don't obtain precertification when required, a non-compliance penalty, per occurrence, will be assessed.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Office Visits	$50/office visit $25/group visit	50% coinsurance	None.
	Outpatient Services	30% coinsurance	50% coinsurance	Precertification is required. If you don't obtain precertification when required, a non-compliance penalty, per occurrence, will be assessed.
	Inpatient Services	30% coinsurance	50% coinsurance	
If you are pregnant	Office visits	$50/visit	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	Limited to 100 visits/calendar year. Precertification is required. If you don't obtain precertification when required, a non-compliance penalty, per occurrence, will be assessed.
	Rehabilitation services	30% coinsurance	50% coinsurance	Limited to 24 visits/calendar year, combined with Physical & Occupational Therapy. In-Network Chiropractic Services are limited to 30 visits/calendar year. Out-of-Network Chiropractic Services are limited to 24 visits/calendar year.
	Habilitation services	30% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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	Skilled nursing care	30% coinsurance	50% coinsurance	Limited to 100 days/calendar year. Precertification is required. If you don't obtain precertification when required, a non-compliance penalty, per occurrence, will be assessed.
	Durable medical equipment	50% coinsurance		Excludes vehicle and home modifications, exercise and bathroom equipment. Precertification is required. If you don't obtain precertification when required, a non-compliance penalty, per occurrence, will be assessed.
	Hospice services	No Charge	50% coinsurance	Precertification is required. If you don't obtain precertification when required, a non-compliance penalty, per occurrence, will be assessed.
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Limited to one exam/12-month period. Routine screenings covered as defined under the Patient Protection and Affordable Care Act of 2010.
	Children's glasses	Not Covered	Not Covered	None.
	Children's dental check-up	Not Covered	Not Covered	Routine screenings covered as defined under the Patient Protection and Affordable Care Act of 2010.

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
- Long Term Care
- Private Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs
- Non-emergency care when travelling outside the US

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)
- Bariatric Surgery
- Chiropractic Care (Limited to 30 visits/calendar year (in-network), or 24 visits/calendar year (out-of-network)
- Infertility Treatment

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: your state insurance department, the US Department of Labor, or Employee Benefits Security Administration at 1-866-444-3272 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: BRMS @ 1-844-814-3437.

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 1-866-772-0324]

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 copayment	**$50**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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	$200
Coinsurance	$3,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,060**

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 copayment	**$50**
Hospital (facility) coinsurance	**30%**
Other (brand drug) copayment	**$50**

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	$100
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,820**

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

The plan's overall deductible	**$1,500**
Specialist copayment	**$50**
Hospital (ER) coinsurance	**30%**
Other coinsurance	**30%**

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	$100
Coinsurance	$810
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,410**

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