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, www.Myevhc.com. 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 1-877-877-3496 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: **$3,000** individual/**$6,000** family per calendar year For out-of-network providers: **$3,000** individual /**$6,000** family per calendar.	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 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?	For in-network providers: **$4,000** individual /**$8,000** family per calendar year.(no more than **$4,000** per individual in the family) For out-of-network providers: **$6,000** individual /**$12,000** family per calendar. (no more than **$8,000** per individual in the 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 and penalties for failure to obtain preauthorization for services.	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 1-877-877-3496 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
		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	0% coinsurance	30% coinsurance	None
	Specialist visit	0% coinsurance	30% coinsurance	None
	Preventive care/screening/ immunization	No charge; deductible does not apply.	30% 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.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	30% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com.	Generic drugs	Retail: $10 copay Mail Order & 90 day supply maintenance meds $30 copay after deductible.	Not covered	Copay and deductible applies to a 31-day supply Retail, 32-90-day supply Mail Order, and 90-day supply of maintenance medications at any retail Pharmacy. Copay and deductible does not apply to preventive drugs required by the Affordable Care Act.
	Preferred brand drugs	Retail: $30 copay Mail Order & 90 day supply maintenance meds $90 copay after deductible.	Not covered	
	Non-preferred brand drugs	Retail: $50 copay Mail Order & 90 day supply maintenance meds $150 copay after deductible.	Not covered	
	Specialty drugs	Same as above	Not covered	Specialty drugs are limited to a 31 day supply for Retail or Mail Order. All Specialty drugs must be obtained through CVS Specialty Pharmacy.
If you have outpatient	Facility fee (e.g., ambulatory surgery	0% coinsurance	30% 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)	
surgery	center)			
	Physician/surgeon fees	0% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$100 copay/visit	In-network providers benefit applies.	Copay waived if admitted.
	Emergency medical transportation	0% coinsurance	In-network providers benefit applies.	None
	Urgent care	0% coinsurance	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	30% coinsurance	Preauthorization is required. Failure to obtain preauthorization may result in a $750 penalty.
	Physician/surgeon fees	0% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	30% coinsurance	None
	Inpatient services	0% coinsurance	30% coinsurance	Preauthorization is required. Failure to obtain preauthorization may result in a $750 penalty.
If you are pregnant	Office visits	0% coinsurance	30% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	0% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	30% coinsurance	
If you need help recovering or have other special health	Home health care	0% coinsurance	30% coinsurance	Limited to 100 visits/calendar year. Preauthorization is required. Failure to obtain preauthorization may result in a $750 penalty.

* For more information about limitations and exceptions, see the plan or policy document at www.Myevhc.com.

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)	
needs	Rehabilitation services	0% coinsurance	30% coinsurance	Limited to 40 visits for Physical therapy and Occupational therapy and 20 visits for Speech and Hearing therapy. Chiropractic care limited 20 visits.
	Habilitation services	0% coinsurance	30% coinsurance	Services are covered when Medically Necessary to treat a mental health condition (e.g. autism).
	Skilled nursing care	0% coinsurance	30% coinsurance	Limited to 100 days/calendar year. Preauthorization is required. Failure to obtain preauthorization may result in a $750 penalty.
	Durable medical equipment	0% coinsurance	30% coinsurance	None
	Hospice services	0% coinsurance	30% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	No coverage
	Children's glasses	Not covered	Not covered	No coverage
	Children's dental check-up	Not covered	Not covered	No coverage

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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Hearing aids
- 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.)

- Chiropractic care (limited to 20 visits)

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: 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: 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 1-877-877-3496.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-877-3496.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-877-877-3496.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-877-3496.

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	**$3,000**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**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**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,000
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,070**

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

The plan's overall deductible	**$3,000**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

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	$1,900
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,420**

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

The plan's overall deductible	**$3,000**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**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)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,800
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,810**

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