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, call Personify Health, LLC at 1-877-706-6268. 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 1-877-706-6268 to request a copy.

Important Questions	Answers		Why This Matters:
What is the overall deductible?	Network *Per Calendar Year* $1,000/individual $3,000/family	Out-of-Network *Per Calendar Year* $2,000/individual $6,000/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.
Are there services covered before you meet your deductible?	Yes, Network Preventive services, services paid with a copayment, and services paid at no charge.		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 *Per Calendar Year* $3,000/individual $9,000/family	Out-of-Network *Per Calendar Year* $6,000/individual $18,000/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 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 (unless balance billing is prohibited), 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	$25/visit, deductible waived	40% coinsurance	None
	Specialist visit	$50/visit, deductible waived	40% coinsurance	
	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.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Precertification may be required for certain services. If you don't get precertification, benefits could be reduced.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available by calling 1-877-908-6024 or by visiting www.navitus.com.	Generic drugs	**Retail** $10/prescription **Mail order** $20/prescription	Not covered	Covers up to a 30-day supply (retail pharmacy); 31-90 day supply (mail order pharmacy). Preventive medication and contraceptives are covered at no charge as required by law. Deductible does not apply. Infertility drugs are limited to a lifetime maximum of $20,000.
	Preferred brand drugs	**Retail** $35/prescription **Mail order** $70/prescription	Not covered	
	Non-preferred brand drugs	**Retail** $65/prescription **Mail order** $130/prescription	Not covered	
	Specialty drugs	**Retail** 20% coinsurance/ Prescription (up to $100 maximum)	Not covered	Deductible does not apply. Specialty drugs must be purchased through a retail pharmacy. Precertification may be required for some Specialty drugs. If you don't get precertification, benefits could be reduced.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Precertification may be required for certain services. If you don't get precertification, benefits could be reduced.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$200/visit, then 20% coinsurance		The copay is waived if you are admitted to the hospital directly from the emergency room.
	Emergency medical transportation	20% coinsurance		None
	Urgent care	$40/visit, deductible waived		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 you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Precertification is required. If you don't get precertification, benefits could be reduced.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Office** $25/visit deductible waived **Other** 20% coinsurance	40% coinsurance	Precertification may be required for facility services. If you don't get precertification, benefits could be reduced.
	Inpatient services	20% coinsurance	40% coinsurance	Precertification is required. If you don't get precertification, benefits could be reduced.
If you are pregnant	Office visits	No charge deductible waived	40% coinsurance	Cost sharing does not apply for network preventive care 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). None
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Precertification is only required for stay exceeding 48 hours after delivery (or 96 hours after C-section). If you don't get precertification when required, benefits could be reduced.

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	20% coinsurance	40% coinsurance	Limited to 120 visits/calendar year. Precertification is required. If you don't get precertification, benefits could be reduced.
	Rehabilitation services	**Office** $50/visit deductible waived **Outpatient** 20% coinsurance	40% coinsurance	Limited to 60 visits/calendar year. Occupational, Physical, Speech, Cognitive, and Pulmonary therapies combined. Cardiac therapy is limited to 36 visits/calendar year.
	Habilitation services	No charge deductible waived	40% coinsurance	None
	Skilled nursing care	**Outpatient** 20% coinsurance	40% coinsurance	Limited to 120 days/calendar year Precertification is required. If you don't get precertification, benefits could be reduced.
	Durable medical equipment	20% coinsurance	40% coinsurance	Precertification may be required for certain services. If you don't get precertification, benefits could be reduced.
	Hospice services	20% coinsurance	40% coinsurance	Precertification may be required for certain services. If you don't get precertification, benefits could be reduced. Services and supplies are available for Plan Participant's with a life expectancy of less than 6 months.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Must enroll in separate vision plan.
	Children's glasses	Not covered	Not covered	Must enroll in separate vision plan..
	Children's dental check-up	Not covered	Not covered	Must enroll in separate dental plan.

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 / Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) / (Child)
- 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/Calendar Year)
- Bariatric surgery (Limited to $10,000/Lifetime)
- Chiropractic care (Limited to 20 visits/Calendar Year)
- Hearing aid
- Private-duty nursing
- 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: Personify Health, LLC at 1-877-706-6268 or the 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: Personify Health, LLC at 1-877-706-6268 or the 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 1-877-706-6268.

*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	$1,000
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other (Tests) coinsurance	20%

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	$1,000
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

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

The plan's overall deductible	$1,000
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other (Brand drugs) coinsurance	20%

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	$900
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,320**

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

The plan's overall deductible	$1,000
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other (Physical therapy) coinsurance	20%

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	$1,000
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,600**

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