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 (800) 372-0905. For general definitions of common terms, such as allowed amount, balance billing, co-insurance, co-payment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.HealthCare.gov/Glossary or call (800) 372-0905 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network **$300** Individual | **$900** Family Out-of-Network **$600** Individual | **$1,800** Family Per Plan Year	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. The plan deductible applies to medical services only. A separate **$250** deductible applies to Specialty Drugs. See below for additional information.
Are there services covered before you meet your deductible?	Yes, In-Network Preventive Care, Primary Care, Specialist Office Visits, Urgent Care, & Non-Specialty Prescription Drugs.	This plan covers some items and services even if you have not met the deductible amount. But a co-pay and co-insurance 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 www.healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	Yes, there is a **$250** deductible for Specialty 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 **$2,500** Individual | **$6,250** Family Out-of-Network **$5,000** Individual | **$12,500** Family Per Plan Year	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. Out-of-pocket accumulations are combined for Medical and Rx.
What is not included in the out-of-pocket limit?	Penalties for failing to obtain prior authorization, amounts in excess of UCR, premiums, balance-billing charges, and health care this plan does not cover.	Even though you pay these expenses, they do not count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. Visit www.Anthem.com/CA or call BRMS at (800) 372-0905 for a list of network providers.	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 receive services.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You may see the specialist you choose without permission from this plan.

All **co-payment** and **co-insurance** 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: In-Network (You will pay the least)	What You Will Pay: Out-of-Network (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary Care Visit to Treat an Injury or Illness	**$20** Co-pay Per Visit, Deductible Waived	**40%** Co-insurance	Benefit includes Chiropractic Services. Chiropractic Services are limited to 30 visits per Plan year. Prior authorization is required for all services exceeding $1,000.
	Specialist Visit	**$20** Co-pay Per Visit, Deductible Waived	**40%** Co-insurance	Prior authorization is required for all services exceeding $1,000.
	Preventive Care, Screening, Immunization	No Charge, Deductible Waived	Not Covered	You may have to pay for services that are not 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 (e.g., X-ray, Blood Work)	**20%** Co-insurance	**40%** Co-insurance	See your Summary Plan Description for additional information regarding Pre-Operative Testing. Prior authorization is required for all services $1,000.
	Imaging (e.g., CT/PET Scans, MRIs)	**20%** Co-insurance	**40%** Co-insurance	See your Summary Plan Description for additional information regarding Pre-Operative Testing. Prior authorization is required for all services exceeding $1,000.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.MaxorPlus.com	Generic Drugs	Retail **$5** Co-pay/Prescription Mail-Order **$10** Co-pay/Prescription	Not Covered	If a Brand Drug is dispensed when the Generic is available, you may be financially responsible for the difference. Retail covers up to a 30-day supply. Mail-Order covers up to a 90-day supply. Prior authorization is required for select drugs.
	Preferred Brand Drugs	Retail **$25** Co-pay/Prescription Mail-Order **$50** Co-pay/Prescription	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
	Non-Preferred Brand Drugs	Retail **$40** Co-pay/Prescription Mail-Order **$80** Co-pay/Prescription	Not Covered	See previous page for limitations, exceptions, & other important information.
	Specialty Drugs	Retail **$60** Co-pay/Prescription	Not Covered	**$250** Specialty Rx deductible applies. Specialty Drugs must be obtained through Maxor Specialty Pharmacy and are subject to the terms of the program. Specialty Drugs are available through retail only and cover up to a 30-day supply. Select drugs may require prior authorization and may be subject to dispensing limits.
If you have outpatient surgery	Facility Fee (e.g., Ambulatory Surgery Center)	**20%** Co-insurance, Deductible Waived	**40%** Co-insurance, Deductible Waived	Prior authorization is required for all services exceeding $1,000.
	Physician/Surgeon Fees	**20%** Co-insurance, Deductible Waived	**40%** Co-insurance, Deductible Waived	Prior authorization is required for all services exceeding $1,000.
If you need immediate medical attention	Emergency Room Care	**$150** Co-pay Per Visit, Plus **20%** Co-insurance	**$150** Co-pay Per Visit, Plus **40%** Co-insurance	Co-pay waived if admitted. Prior authorization is required for all services exceeding $1,000. Emergency Room Care for non-emergencies is not covered.
	Emergency Medical Transportation	**20%** Co-insurance		Out-of-Network is covered as In-Network. Includes emergency air transportation. Prior authorization is required for all services exceeding $1,000.
	Urgent Care	**$20** Co-pay Per Visit, Deductible Waived	**40%** Co-insurance	Prior authorization is required for all services exceeding $1,000.
If you have a hospital stay	Facility Fee (e.g., Hospital Room)	**20%** Co-insurance	**40%** Co-insurance	Prior authorization is required for all services exceeding $1,000.
	Physician/Surgeon Fees	**20%** Co-insurance	**40%** Co-insurance	Benefit includes fees for Surgical Assistants and Anesthesiologists. Prior authorization is required for all services exceeding $1,000.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient Services	**$20** Co-pay Per Visit, Deductible Waived	**40%** Co-insurance	Benefit includes Mental Health Office Visits. Prior authorization is required for all services exceeding $1,000.
	Inpatient Services	**20%** Co-insurance	**40%** Co-insurance	Prior authorization is required for all services exceeding $1,000.
If you are pregnant	Office Visits	**20%** Co-insurance	**40%** Co-insurance	Coverage is for Employee and Spouse only. Cost-sharing does not apply to preventive services. Depending on the types of services, co-insurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Prior authorization is required for hospital stay exceeding 48 hours after vaginal delivery, or 96 hours after C-section.
	Childbirth/Delivery Professional Services	**20%** Co-insurance	**40%** Co-insurance	
	Childbirth/Delivery Facility Services	**20%** Co-insurance	**40%** Co-insurance	
If you need help recovering or have other special health needs	Home Health Care	**20%** Co-insurance	**40%** Co-insurance	Coverage is limited to 100 visits per Plan year. Prior authorization is required for all services exceeding $1,000.
	Rehabilitation Services	**$20** Co-pay Per Visit, Deductible Waived	**40%** Co-insurance	Physical, Occupational, & Speech Therapies are limited to a combined 60 visits per Plan year. Prior authorization is required for all services exceeding $1,000.
	Habilitation Services	**$20** Co-pay Per Visit, Deductible Waived	**40%** Co-insurance	Coverage includes Cardiac, Pulmonary, & Respiratory Therapies. Prior authorization is required for all services exceeding $1,000.
	Skilled Nursing Care	**20%** Co-insurance	**40%** Co-insurance	Coverage is limited to 120 visits per Plan year. Prior authorization is required for all services exceeding $1,000.
	Durable Medical Equipment	**20%** Co-insurance	**40%** Co-insurance	Prior authorization is required for all supplies & services exceeding $1,000.
	Hospice Services	**20%** Co-insurance	**40%** Co-insurance	Coverage is limited to 120 visits per Plan year. Prior authorization is required for all services exceeding $1,000.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If your child needs dental or eye care	Children's Eye Exam	No Charge for Preventive Vision Screenings, Deductible Waived	Not Covered	Vision Screenings are covered as indicated under preventive care services.
	Children's Glasses	Not Covered	Not Covered	Covered under the Vision Benefit Plan.
	Children's Dental Check-up	Not Covered	Not Covered	Covered under the Dental Benefit 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.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult & Child)
- Hearing Aids
- Infertility Treatment
- Non-Emergency Care when traveling outside the U.S.
- 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.)

- Bariatric Surgery
- Chiropractic Care
- Private Duty Nursing
- Routine Eye Care (Adult & Child)
- Long Term Care

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 or you can call Benefit & Risk Management Services at (800) 372-0905.

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 (800) 372-0905.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 372-0905.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 (800) 372-0905.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 372-0905.

*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, co-payments and co-insurance) 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** **$300**
- **Specialist co-payment** **$20**
- **Hospital (facility) co-insurance** **20%**
- **Other co-insurance** **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	$300
Co-payments	$0
Co-insurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,560**

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

- **The plan's overall deductible** **$300**
- **Specialist co-payment** **$20**
- **Hospital (facility) co-insurance** **20%**
- **Other co-insurance** **20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Medical Supplies *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost-sharing	
Deductibles	$300
Co-payments	$800
Co-insurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,220**

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

- **The plan's overall deductible** **$300**
- **Specialist co-payment** **$20**
- **Hospital (facility) co-insurance** **20%**
- **Other co-insurance** **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	$300
Co-payments	$250
Co-insurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$950**

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