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, please contact the Health Benefits Department at (530) 378-8200. 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 (530) 378-8200 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$250/individual or $500/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, Preventive care	This plan covers some items and services even if you haven't yet met the deductible amount. 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?	$2,000/individual or $4,000/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 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.	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 (530) 378-8200 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.

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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	20% coinsurance	20% coinsurance	None
	Specialist visit	20% coinsurance	20% coinsurance	None
	Preventive care/screening/ immunization	No charge	Not covered	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.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at (530) 378-8200	Generic drugs	20% coinsurance (retail & mail order)	Not covered	Prescription receipt must be submitted to the Plan for reimbursement.
	Preferred brand drugs	40% coinsurance (retail & mail order)	Not covered	Prescription receipt must be submitted to the Plan for reimbursement.
	Non-preferred brand drugs	40% coinsurance (retail & mail order)	Not covered	Prescription receipt must be submitted to the Plan for reimbursement.
	Specialty drugs	40% coinsurance	Not covered	Prescription receipt must be submitted to the Plan for reimbursement.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance.	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance. 25% penalty	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	None

[* For more information about limitations and exceptions, see your Plan Document/Summary Plan Description.]

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 mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	20% coinsurance	Substance abuse treatment not covered.
	Inpatient services	20% coinsurance	20% coinsurance. 25% penalty	Preauthorization is required. Substance abuse treatment not covered.
If you are pregnant	Office visits	20% coinsurance	20% coinsurance	Limited to employees and spouses. Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply.
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	Limited to employees and spouses.
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance. 25% penalty	Limited to employees and spouses.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Registered nurses only. In Lieu of hospitalization only.
	Rehabilitation services	20% coinsurance	20% coinsurance	18 visits/12 month limit
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	20% coinsurance	20% coinsurance	Registered nurses only. In Lieu of hospitalization.
	Durable medical equipment	20% coinsurance	20% coinsurance	Limited to DME on policy list.
	Hospice services	Not covered	Not covered	Not covered
If your child needs dental or eye care	Children's eye exam	20% coinsurance	20% coinsurance	80% of $200/24-months
	Children's glasses	20% coinsurance	20% coinsurance	
	Children's dental check-up	20% coinsurance	20% coinsurance	80% of $1250/year

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
- Infertility treatment
- Long-term care
- Private-duty nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery (Weight Management Program)
- Chiropractic care
- Dental care (Adult)
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care (excludes orthotics)
- Weight loss program

[* For more information about limitations and exceptions, see your Plan Document/Summary Plan Description.]

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: 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 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: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the California Consumer Assistance Program operated by the California Department of Managed Health Care and Department of Insurance, at (888) 466-2219 or http://www.healthhelp.ca.gov. A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthreform and http:www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-800-225-5254, customer code: 99937
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-225-5254, customer code: 99937
[Chinese (中文): 如果需要中文的帮助， 请拨打这个号码1-800-225-5254, customer code: 99937
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-225-5254, customer code: 99937

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

[* For more information about limitations and exceptions, see your Plan Document/Summary Plan Description.]

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	$250
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other 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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$1,750
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,060**

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

The plan's overall deductible	$250
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other 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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$1,750
What isn't covered	
Limits or exclusions	$500
The total Joe would pay is	**$2,500**

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

The plan's overall deductible	$250
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other 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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$30
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$280**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: the Health Benefits Department (530) 378-8200.

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