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, visit us at www.MyHealthBenefits.com. 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/SBC-Glossary, or call 888-274-4818 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Medical & Rx Individual / Family **$0** *Calendar Year*	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes, services including but not limited to Primary Care Visits, Specialist Visits, Preventive Care Visits, Urgent Care Visits, and Prescription Drugs, are all covered without application of a deductible.	This plan covers some items and services even if you have not met the deductible amount. But a co-payment 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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You do not have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical Individual **$1,000** Medical Family **$3,000** Rx Individual **$2,500** Rx Family **$3,500** *Calendar 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.
What is not included in the out-of-pocket limit?	Prior authorization penalties, premiums, balance-billing charges, co-payments for certain services, 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. Please visit www.Anthem.com/CA or call BRMS at 888-274-4818 for more information on participating providers.	The plan uses a provider network. You will pay less if you use a provider in the plan's network. You pay more 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 in-network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you receive services.
Do you need a referral to see a specialist?	No.	You may see the specialist you choose without a referral.

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		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	First 3 Visits $0 Copay/visit After 3rd Visit $10 Copay/visit	First 3 Visits *$0 Copay/visit After 3rd Visit *$10 Copay/visit	*Out-of-network services are subject to the maximum allowable amount. Coverage is also applicable to Virtual Visits.
	Specialist Visit	$10 Copay/visit	*$10 Copay/visit	*Out-of-network services are subject to the maximum allowable amount.
	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 needed are preventive, then check what your plan will pay for.
If you have a test	Diagnostic Test (e.g., X-Ray, Blood Work)	No Charge	Not Covered	None.
	Imaging (e.g., CT/PET Scans, MRIs)	No Charge	*No Charge	*Out-of-network services are subject to a benefit maximum of **$800** per service, not to exceed the maximum allowable amount. Pre-authorization is required. Participants are encouraged to call BRMS prior to receiving services at 1-888-274-4818. Failure to obtain pre-authorization may result in reduced benefits or non-payment by the plan.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Navitus.com.	Generic Drugs	Costco Retail $0 Copay/prescription Other Retail $9 Copay/prescription Costco Mail-Order $0 Copay/prescription	Member must pay the entire cost up front and apply for reimbursement. Net cost may be greater than if member uses an in-network provider.	Some narcotic drugs and cough medications are subject to the **$9** Retail co-payment at Costco Pharmacy and 3 times the regular co-payment for Mail-Order. If a Brand Drug is dispensed when a Generic equivalent is available, the member will be responsible for the Generic co-payment plus

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 (cont.) More information about **prescription drug coverage** is available at www.Navitus.com.	Preferred Brand Drugs	Costco / Other Retail $35 Copay/prescription Costco Mail-Order $90 Copay/ prescription	Member must pay the entire cost up front and apply for reimbursement. Net cost may be greater than if member uses an in-network provider.	the cost difference between the Generic and Brand Drugs. Generic and Brand Drug Retail options cover up to a 30-day supply. Mail-Order options are available through Costco Pharmacy only and cover up to a 90-day supply.
	Specialty Drugs	Navitus Mail-Order $35 Copay/prescription	Not Covered	Specialty Mail-Order option is available through Navitus only and covers up to a 30-day supply. Pre-authorization, step therapy, and quantity limits may apply.
If you have outpatient surgery	Facility Fee (e.g., ambulatory surgical center)	No Charge	*No Charge	*Out-of-network services are subject to a benefit maximum of **$350** per day, not to exceed the maximum allowable amount. Pre-authorization is required. Participants are encouraged to call BRMS prior to surgery at 1-888-274-4818. Failure to obtain pre-authorization may result in reduced benefits or non-payment by the plan. See Plan Document for additional limitations.
	Physician/Surgeon Fees	No Charge	*No Charge	*Out-of-network services are subject to the maximum allowable amount.
If you need immediate medical attention	Emergency Room Care	$100 Copay/visit		Co-payment waived if admitted.
	Emergency Medical Transportation	$100 Copay/trip		Benefits for non-Emergency air ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.
	Urgent Care	$10 Copay/visit	*$10 Copay/visit	*Out-of-network services are subject to the maximum allowable amount.

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)	No Charge	*No Charge	*Out-of-network services are subject to a benefit maximum of **$600** per day, not to exceed the maximum allowable amount. Pre-authorization is required. Participants are encouraged to call BRMS prior to any inpatient stay at 1-888-274-4818. Failure to obtain pre-authorization may result in reduced benefits or non-payment by the plan. See Plan Document for additional limitations.
	Physician/Surgeon Fees	No Charge	*No Charge	*Out-of-network services are subject to the maximum allowable amount.
If you need mental health, behavioral health, or substance abuse services	Outpatient Services	Office / Virtual / Home First 3 Visits $0 Copay/visit Office / Virtual / Home After 3rd Visit $10 Copay/visit Facility No Charge	Office / Virtual / Home First 3 Visits *$0 Copay/visit Office / Virtual / Home After 3rd Visit *$10 Copay/visit Facility *No Charge	*Out-of-network services are subject to the maximum allowable amount.
	Inpatient Services	No Charge	*No Charge	*Out-of-network services are subject to a benefit maximum of **$600** per day, not to exceed the maximum allowable amount. Pre-authorization is required. Participants are encouraged to call BRMS prior to any inpatient stay at 1-888-274-4818. Failure to obtain pre-authorization may result in reduced benefits or non-payment by the plan.

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 are pregnant	Office Visits	First 3 Visits $0 Copay/visit After 3rd Visit $10 Copay/visit	No Coinsurance	*Out-of-network services are subject to the maximum allowable amount. Cost-sharing does not apply for in-network preventive services. Depending on the types of services, co-pay, co-insurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasounds).
	Childbirth/Delivery Professional Services	No Charge	*No Charge	*Out-of-network services are subject to a benefit maximum of **$600** per day, not to exceed the maximum allowable amount. Participants are encouraged to call BRMS prior to delivery at 1-888-274-4818. Pre-authorization is only required for stays exceeding 48 hours after normal delivery or 96 hours after C-section.
	Childbirth/Delivery Facility Services	No Charge	*No Charge	
If you need help recovering or have other special health needs	Home Health Care	No Charge	*No Charge	*Out-of-network Home Infusion Therapy/ Chemotherapy is subject to a benefit maximum of **$600** per day. Out-of-network Home Dialysis is subject to a benefit maximum of **$350** per day. All other out-of-network Home Health Care is subject to a benefit maximum of **$150** per day. Each benefit maximum is not to exceed the maximum allowable amount. Coverage is limited to **100 visits**/Calendar Year and **4 hours** or less per visit, combined in-network and out-of-network. This limit does not apply to Home Infusion Therapy, Home Chemotherapy, or Home Dialysis. Pre-authorization is required. Participants are encouraged to call BRMS prior to receiving services at 1-888-274-4818. Failure to obtain pre-authorization may result in reduced benefits or non-payment by the plan.

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 (cont.)	Rehabilitation Services	Benefits are based on the setting in which covered services are received.	Benefits are based on the setting in which covered services are received.	See Plan document for limitations, exclusions, and pre-authorization requirements. Participants are encouraged to call BRMS prior to receiving services at 1-888-274-4818.
	Habilitation Services			
	Skilled Nursing Care	No Charge	*No Charge	*Out-of-network services are subject to a benefit maximum of **$600** per day, not to exceed the maximum allowable amount. Coverage is limited to **150 days**/Calendar Year, combined in and out-of-network. Pre-authorization is required. Participants are encouraged to call BRMS prior to receiving services at 1-888-274-4818. Failure to obtain pre-authorization may result in reduced benefits or non-payment by the plan.
	Durable Medical Equipment	No Charge	Not Covered	Pre-authorization is required. Participants are encouraged to call BRMS prior to receiving services at 1-888-274-4818. Failure to obtain pre-authorization may result in reduced benefits or non-payment by the plan. See Plan Document for additional limitations.
	Hospice Services	No Charge	*No Charge	*Out-of-network services are subject to the maximum allowable amount. Pre-authorization is required. Participants are encouraged to call BRMS prior to receiving services at 1-888-274-4818. Failure to obtain pre-authorization may result in reduced benefits or non-payment by the plan.
If your child needs dental or eye care	Children's Eye Exam	No Charge for Preventive Vision Screenings	Not Covered	In-network Vision Screenings are covered as indicated under preventive care services. Routine eye exams are not covered under the Medical Plan.
	Children's Glasses	Not Covered	Not Covered	None.
	Children's Dental Check-Up	Not Covered	Not Covered	None.

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) • Infertility treatment	• Long-term care • Non-emergency care when traveling outside the U.S. • Private duty nursing	• Routine foot care • Routine eye care (Adult/Child) • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Bariatric surgery	• Chiropractic care	• Hearing aids

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/Agencies/EBSA. 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:

Benefit & Risk Management Services
P.O. Box 2140
Folsom, CA 95673
888-274-4818

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 888-274-4818.

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 prenatal care and a hospital delivery)

The plan's overall deductible	$0
Specialist co-pay	$10
Hospital (facility) co-insurance	0%
Other co-insurance	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	$0
Co-payments	$20
Co-insurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$80**

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

The plan's overall deductible	$0
Specialist co-pay	$10
Hospital (facility) co-insurance	0%
Other co-insurance	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	$0
Co-payments	$700
Co-insurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$720**

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

The plan's overall deductible	$0
Specialist co-pay	$10
Hospital (facility) co-insurance	0%
Other co-insurance	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	$0
Co-payments	$300
Co-insurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$300**

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