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.anthem.com/ca. 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 1-833-271-4121 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier 1 AVMC Preferred Provider: No deductible. All services performed at AVMC (TIN 95-6005217) will be considered Tier 1. Tier 2 Anthem Preferred Provider: $500/individual or $1,000/family per plan year. Tier 3 Nonpreferred Provider: None.	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. Prescription drugs, and the following services by a Tier 1 AVMC preferred provider and/or tier 2 Anthem preferred provider: Preventive care, emergency room care, urgent care, rehabilitative services, habilitative services, specialist and primary care physician 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?	Tier 1 AVMC Preferred Provider: $1,000/individual, $2,000/two-person family or $3,000/family per plan year. Tier 2 Anthem Preferred Provider: $3,000/individual, $5,000/two-person family, and $8,000/family per plan year. Tier 3 Nonpreferred provider: None.	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?	Penalties for failure to obtain pre-certification for services, premiums, balance-billing charges, prescription drugs and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit. Prescription drugs charges are not applicable to the medical out-of-pocket limit -they apply to the Prescription drug out-of-pocket limit .
Will you pay less if you use a network provider?	Yes. See www.anthem.com/ca or call 1-833-271-4121 for a list of network providers.	You pay the least if you use a Tier 1 AVMC preferred provider. You pay more if you use a Tier 2 Anthem preferred provider. You will pay the most if you use a Tier 3 nonpreferred 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 Tier 1 AVMC preferred provider or Tier 2 Anthem preferred provider might use a Tier 3 nonpreferred provider for some services (such as lab work). Check with your provider before you get services.

Important Questions	Answers	Why This Matters:
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
		Tier 1 AVMC Provider Preferred Provider (You will pay the least)	Tier 2 Anthem Preferred Provider (You will pay the least)	Tier 3 Nonpreferred 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	Not Applicable	$20 copayment/visit (deductible does not apply)	Not covered	Benefit applies to exam/visit only. Additional services rendered during the visit may apply deductible/coinsurance. Telemedicine: Tier 1 AVMC preferred provider: Not covered Tier 2 Anthem preferred provider: $10 copayment Tier 3 nonpreferred provider: Not covered
	Specialist visit	Not Applicable	$30 copayment/visit (deductible does not apply)	Not covered	
	Preventive care/screening/immunization	0% coinsurance (deductible does not apply)	0% coinsurance (deductible does not apply)	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 (x-ray, blood work)	0% coinsurance (deductible does not apply)	20% coinsurance	Not covered	None.
	Imaging (CT/PET scans, MRIs)	0% coinsurance (deductible does not apply)	20% coinsurance	Not covered	Pre-certification is required for some services. Call 1-800-274-7767.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Retail Pharmacy (30-day supply)	Mail Order Pharmacy (90-day supply)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.rxbenefits.com or call 1-800-334-8134	Prescription Out-of-Pocket Limit	**$2000/Person $5,000/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.
	Generic drugs	Retail: $10 copayment/ prescription (deductible does not apply)	Mail order: $20 copayment/prescription (deductible does not apply)	Copayment applies to a 30-day supply Retail and Specialty drugs 90 day supply Mail-Order prescription. A 90-day supply of maintenance medications are available at the retail pharmacy for the mail order copayment. Copayment does not apply to preventive drugs required by the Affordable Care Act. If you purchase a brand name drug when the physician has indicated a generic drug can be dispensed, you must pay difference in cost. If you purchase a brand name drug when a generic drug is available, you must pay difference in cost. Prescriptions obtained from non-participating retail pharmacies will apply the applicable copayment plus 50%.
	Preferred drugs	Retail: $25 copayment/ prescription (deductible does not apply)	Mail order: $50 copayment/prescription (deductible does not apply)	
	Non-preferred drugs	Retail: $40 copayment/ prescription (deductible does not apply)	Mail order: $80 copayment/prescription (deductible does not apply)	
	Specialty drugs	Retail: $25 copayment/ prescription (deductible does not apply)	Mail order: $50 copayment/prescription (deductible does not apply)	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 AVMC Provider Preferred Provider (You will pay the least)	Tier 2 Anthem Preferred Provider (You will pay the least)	Tier 3 Nonpreferred Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	20% coinsurance	Not covered	Pre-certification is required for some services.
	Physician/surgeon fees	0% coinsurance	20% coinsurance	Not covered	Pre-certification is required for some services.
If you need immediate medical attention	Emergency room care	$100 copayment/visit (deductible does not apply)			Copayment waived if admitted.
	Emergency medical transportation	Not Applicable	20% coinsurance		None.
	Urgent care	Not Available	$20 copayment/visit (deductible does not apply)	Not covered	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	20% coinsurance	Not covered	Pre-certification is required.
	Physician/surgeon fees	0% coinsurance	20% coinsurance	Not covered	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: Not Available Other Outpatient Services: Not Available	Office: $20 copayment/ visit (deductible does not apply) Other Outpatient Services: 20% coinsurance	Not covered	Pre-certification is required for some services.
	Inpatient services	0% coinsurance	20% coinsurance	Not covered	Pre-certification is required.

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

The AVMC provider benefit applies only to provider who bills under AVMC TIN 95-6005217

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 AVMC Provider Preferred Provider (You will pay the least)	Tier 2 Anthem Preferred Provider (You will pay the least)	Tier 3 Nonpreferred Provider (You will pay the most)	
If you are pregnant	Office visits	Not Applicable	$20 copayment/visit (deductible does not apply)	Not covered	Dependent daughters are not covered for this benefit. Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	0% coinsurance	20% coinsurance	Not covered	
	Childbirth/delivery facility services	0% coinsurance	20% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	$20 copayment/visit	Not covered	Home health care visits limited to 100 visits per plan year. Pre-certification is required.
	Rehabilitation services	0% coinsurance	$20 copayment/visit	Not covered	Pre-certification is required for some services. Limited to 24 visits combined for chiropractic care, physical therapy, speech therapy, and occupational therapy per plan year.
	Habilitation services	0% coinsurance	$20 copayment/visit	Not covered	
	Skilled nursing care	0% coinsurance	20% coinsurance	Not covered	Skilled nursing care limited to 100 days per plan year. Pre-certification is required.
	Durable medical equipment	0% coinsurance	20% coinsurance	Not covered	None.
	Hospice services	0% coinsurance	20% coinsurance	Not covered	Pre-certification is required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	None.
	Children's glasses	Not covered	Not covered	Not covered	None.
	Children's dental check-up	Not covered	Not covered	Not covered	None.

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

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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)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Infertility treatment
- Routine foot care
- Weight loss programs
- Routine eye care (Adult)

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

- Acupuncture
- Bariatric surgery - (Limited to Blue Distinction Facilities only)
- Chiropractic Care - (Limited to 24 visits combined for chiropractic care, physical therapy, speech therapy, and occupational therapy per plan year)
- Private-duty nursing as part of home health care/hospice

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 1-833-271-4121.
Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-833-271-4121.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-271-4121.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-833-271-4121 uff.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-271-4121.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-833-271-4121.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-833-271-4121.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-833-271-4121.

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	$500
Specialist copayment	$30
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$10
Coinsurance	$1,600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,170**

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

The plan's overall deductible	$500
Specialist copayment	$30
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$900
Coinsurance	$60
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,480**

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

The plan's overall deductible	$500
Specialist copayment	$30
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$300
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$860**

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