

 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](http://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:
<u>What is the overall deductible?</u>	Tier 1 AVMC <u>Preferred Provider</u> : \$250/individual or \$500/family per <u>plan</u> year. Tier 2 Anthem <u>Preferred Provider</u> : \$600/individual or \$1,200/family per <u>plan</u> year. Tier 3 <u>Nonpreferred provider</u> : \$1,200/individual or \$2,400/family per <u>plan</u> year. The deductible is combined for Tier 1 AVMC <u>Preferred Provider</u> , Tier 2 Anthem <u>Preferred Provider</u> and Tier 3 <u>Nonpreferred provider</u> services.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<u>Are there services covered before you meet your deductible?</u>	Yes. <u>Prescription drugs</u> , and the following services by a Tier 1 AVMC <u>preferred provider</u> and/or tier 2 Anthem <u>preferred provider</u> : <u>Preventive care</u> , <u>specialist</u> , and <u>primary care physician</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<u>Are there other deductibles for specific services?</u>	No.	You don't have to meet <u>deductibles</u> for specific services.
<u>What is the out-of-pocket limit for this plan?</u>	Tier 1 AVMC <u>Preferred Provider</u> : \$1,000/individual, \$2,000/two-person family, and \$3,000/family per <u>plan</u> year. Tier 2 Anthem <u>Preferred Provider</u> : \$3,000/individual, \$5,000/two-person family, and \$8,000/family per <u>plan</u> year. Tier 3 <u>Nonpreferred provider</u> : \$6,000/individual, \$10,000/two-person family, and \$16,000/family per <u>plan</u> year.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<u>What is not included in the out-of-pocket limit?</u>	Penalties for failure to obtain <u>pre-certification</u> for services, <u>premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<u>Will you pay less if you use a network provider?</u>	Yes. See <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> or call 1-833-271-4121 for a list of network providers.	You pay the least if you use a Tier 1 AVMC <u>preferred provider</u> . You pay more if you use a Tier 2 Anthem <u>preferred provider</u> . You will pay the most if you use a Tier 3 <u>nonpreferred provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance-billing</u> ). Be aware, your Tier 1 AVMC <u>preferred provider</u> or Tier 2 Anthem <u>preferred provider</u> might use a Tier 3 <u>nonpreferred provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<u>Do you need a referral to see a specialist?</u>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	Not Applicable	\$20 <u>copayment</u> /visit ( <u>deductible</u> does not apply)	50% <u>coinsurance</u>	Benefit applies to exam/visit only. Additional services rendered during the visit may apply deductible/coinsurance.
	Specialist visit	Not Applicable	\$30 <u>copayment</u> /visit ( <u>deductible</u> does not apply)	50% <u>coinsurance</u>	Telemedicine: Tier 1 AVMC <u>preferred provider</u> : Not covered Tier 2 Anthem <u>preferred provider</u> : \$10 copayment/visit Tier 3 <u>nonpreferred provider</u> : Not covered Telephone consultations with other physicians will be paid under the appropriate benefit category.
	Preventive care/screening /immunization	0% <u>coinsurance</u> ( <u>deductible</u> does not apply)	0% <u>coinsurance</u> ( <u>deductible</u> does not apply)	50% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None.
	Imaging (CT/PET scans, MRIs)	0% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Pre-certification</u> is required for some services. Call 1-800-274-7767.

\* For more information about limitations and exceptions, see the plan or policy document at [www.myluminarehealth.com](http://www.myluminarehealth.com).

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

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)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.rxbenefits.com">www.rxbenefits.com</a> or call 1-800-334-8134</p>	Prescription Out-of-Pocket Limit	<b>\$2000/Person \$6,000/Family</b>		The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
	Generic drugs	Retail: \$10 <a href="#">copayment</a> /prescription ( <a href="#">deductible</a> does not apply)	Mail order: \$20 <a href="#">copayment</a> /prescription ( <a href="#">deductible</a> does not apply)	<a href="#">Copayment</a> applies to a 30-day supply Retail and <a href="#">Specialty drugs</a> 90 day supply Mail-Order prescription.
	Preferred drugs	Retail: \$25 <a href="#">copayment</a> /prescription ( <a href="#">deductible</a> does not apply)	Mail order: \$50 <a href="#">copayment</a> /prescription ( <a href="#">deductible</a> does not apply)	A 90-day supply of maintenance medications are available at the retail pharmacy for the mail order <a href="#">copayment</a> .  <a href="#">Copayment</a> does not apply to preventive drugs required by the Affordable Care Act.
	Non-preferred drugs	Retail: \$40 <a href="#">copayment</a> /prescription ( <a href="#">deductible</a> does not apply)	Mail order: \$80 <a href="#">copayment</a> /prescription( <a href="#">deductible</a> does not apply)	If you purchase a brand name drug when the physician has indicated a generic drug can be dispensed, you must pay difference in cost.
	<a href="#">Specialty drugs</a>	Retail: \$25 <a href="#">copayment</a> /prescription ( <a href="#">deductible</a> does not apply)	Mail order: \$50 <a href="#">copayment</a> /prescription ( <a href="#">deductible</a> does not apply)	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 <a href="#">copayment</a> plus 50%.

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 AVMC 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% <a href="#">coinsurance</a>	\$500 <a href="#">copayment</a> then 20% <a href="#">coinsurance</a>	\$500 <a href="#">copayment</a> then 50% <a href="#">coinsurance</a>	<a href="#">Pre-certification</a> is required for some services.
	Physician/surgeon fees	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Pre-certification</a> is required for some services.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$100 <a href="#">copayment</a> /visit then 20% <a href="#">coinsurance</a>			<a href="#">Copayment</a> waived if admitted.
	<a href="#">Emergency medical transportation</a>	Not Applicable	20% <a href="#">coinsurance</a>		None.
	<a href="#">Urgent care</a>	Not Available	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% <a href="#">coinsurance</a>	\$500 <a href="#">copayment</a> /admission then 20% <a href="#">coinsurance</a>	\$500 <a href="#">copayment</a> /admission then 50% <a href="#">coinsurance</a>	<a href="#">Pre-certification</a> is required.
	Physician/surgeon fees	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None.

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 AVMC 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 need mental health, behavioral health, or substance abuse services	Outpatient services	Office: Not Available Other Outpatient Services: Not Available	Office: \$20 <u>copayment</u> /visit ( <u>deductible</u> does not apply) Other Outpatient Services: 20% <u>coinsurance</u>	Office: 50% <u>coinsurance</u> Other Outpatient Services: 50% <u>coinsurance</u>	<u>Pre-certification</u> is required for some services.
	Inpatient services	0% <u>coinsurance</u>	\$500 <u>copayment</u> /admission then 20% <u>coinsurance</u>	\$500 <u>copayment</u> /admission then 50% <u>coinsurance</u>	<u>Pre-certification</u> is required.
If you are pregnant	Office visits	Not Applicable	\$20 <u>copayment</u> /visit ( <u>deductible</u> does not apply)	50% <u>coinsurance</u>	Dependent daughters are not covered for this benefit.  <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	0% <u>coinsurance</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	0% <u>coinsurance</u>	\$500 <u>copayment</u> /admission then 20% <u>coinsurance</u>	\$500 <u>copayment</u> /admission then 50% <u>coinsurance</u>	

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 AVMC 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 need help recovering or have other special health needs	<a href="#">Home health care</a>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Home health care</a> visits limited to 100 visit per <a href="#">plan</a> year. <a href="#">Pre-certification</a> is required.
	<a href="#">Rehabilitation services</a>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Pre-certification</a> is required for some services.
	<a href="#">Habilitation services</a>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Limited to 24 visits combined for chiropractic care, physical therapy, speech therapy, and occupational therapy per <a href="#">plan</a> year.
	<a href="#">Skilled nursing care</a>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Skilled nursing care</a> limited to 100 days per <a href="#">plan</a> year. <a href="#">Pre-certification</a> is required.
	<a href="#">Durable medical equipment</a>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None.
	<a href="#">Hospice services</a>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Pre-certification</a> 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.

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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	• Infertility treatment	• Routine eye care (Adult)
• Dental care (Adult)	• Long-term care	• Routine foot care
• Hearing aids	• Non-emergency care when traveling outside the U.S.	• 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 \$30 per visit)	• Chiropractic Care - (Limited to 24 visits combined for chiropractic care, physical therapy, speech therapy, and occupational therapy per <u>plan</u> year)	• Private-duty nursing as part of home health care/hospice
• Bariatric/Transplant surgery - (Limited to Blue Distinction Facilities only)		

**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](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](http://HealthInsuranceMarketplace.gov). For more information about the [Marketplace](http://Marketplace.gov), visit [www.HealthCare.gov](http://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](http://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 a'ohwol ninisingo, kwijjigo 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, á'gang 1-833-271-4121.

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

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## 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 <a href="#">plan's</a> overall (Tier 2 Anthem <a href="#">preferred provider</a> deductible)	\$600
■ <a href="#">Specialist</a>	\$30
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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	
<a href="#">Deductibles</a>	\$600
<a href="#">Copayments</a>	\$30
<a href="#">Coinsurance</a>	\$2,400

#### What isn't covered

Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,060</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall (Tier 2 Anthem <a href="#">preferred provider</a> deductible)	\$600
■ <a href="#">Specialist</a>	\$30
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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	
<a href="#">Deductibles</a>	\$600
<a href="#">Copayments</a>	\$800
<a href="#">Coinsurance</a>	\$100

#### What isn't covered

Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,520</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall (Tier 2 Anthem <a href="#">preferred provider</a> deductible)	\$600
■ <a href="#">Specialist</a>	\$30
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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	
<a href="#">Deductibles</a>	\$600
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$300

#### What isn't covered

Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,100</b>