

 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:
<b>What is the overall <a href="#">deductible</a>?</b>	Tier 1 AVMC <a href="#">Preferred Provider</a> : No deductible. All services performed at AVMC (TIN 95-6005217) will be considered Tier 1. Tier 2 Anthem <a href="#">Preferred Provider</a> : \$500/individual or \$1,000/family per <a href="#">plan</a> year. Tier 3 <a href="#">Nonpreferred Provider</a> : None.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Prescription drugs</a> , and the following services by a Tier 1 AVMC <a href="#">preferred provider</a> and/or tier 2 Anthem <a href="#">preferred provider</a> : <a href="#">Preventive care</a> , <a href="#">emergency room care</a> , <a href="#">urgent care</a> , <a href="#">rehabilitative services</a> , <a href="#">habilitative services</a> , <a href="#">specialist</a> and <a href="#">primary care physician</a> are covered before you meet your <a href="#">deductible</a>	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	Tier 1 AVMC <a href="#">Preferred Provider</a> : \$1,000/individual, \$2,000/two-person family or \$3,000/family per <a href="#">plan</a> year. Tier 2 Anthem <a href="#">Preferred Provider</a> : \$3,000/individual, \$5,000/two-person family, and \$8,000/family per <a href="#">plan</a> year. Tier 3 <a href="#">Nonpreferred provider</a> : None.	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.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	Penalties for failure to obtain <a href="#">pre-certification</a> for services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, <a href="#">prescription drugs</a> and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> . <a href="#">Prescription drugs</a> charges are not applicable to the medical <a href="#">out-of-pocket limit</a> -they apply to the <a href="#">Prescription drug out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	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 <a href="#">preferred provider</a> . You pay more if you use a Tier 2 Anthem <a href="#">preferred provider</a> . You will pay the most if you use a Tier 3 <a href="#">nonpreferred provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance-billing</a> ). Be aware, your Tier 1 AVMC <a href="#">preferred provider</a> or Tier 2 Anthem <a href="#">preferred provider</a> might use a Tier 3 <a href="#">nonpreferred provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.

Important Questions	Answers	Why This Matters:
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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 <a href="#">provider's</a> office or clinic	<a href="#">Primary care</a> visit to treat an injury or illness	Not Applicable	\$20 <a href="#">copayment</a> /visit ( <a href="#">deductible</a> does not apply)	Not covered	Benefit applies to exam/visit only. Additional services rendered during the visit may apply <a href="#">deductible/coinsurance</a> .  Telemedicine: Tier 1 AVMC <a href="#">preferred provider</a> : Not covered Tier 2 Anthem <a href="#">preferred provider</a> : \$10 copayment Tier 3 <a href="#">nonpreferred provider</a> : Not covered
	<a href="#">Specialist</a> visit	Not Applicable	\$30 <a href="#">copayment</a> /visit ( <a href="#">deductible</a> does not apply)	Not covered	
	<a href="#">Preventive care/screening</a> /immunization	0% <a href="#">coinsurance</a> ( <a href="#">deductible</a> does not apply)	0% <a href="#">coinsurance</a> ( <a href="#">deductible</a> does not apply)	Not covered	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	0% <a href="#">coinsurance</a> ( <a href="#">deductible</a> does not apply)	20% <a href="#">coinsurance</a>	Not covered	None.
	Imaging (CT/PET scans, MRIs)	0% <a href="#">coinsurance</a> ( <a href="#">deductible</a> does not apply)	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Pre-certification</a> 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 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
		Retail Pharmacy (30-day supply)	Mail Order Pharmacy (90-day supply)	
<p><b>If you need drugs to treat your illness or condition</b></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 \$5,000/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> .
	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)	<a href="#">Copayment</a> does not apply to preventive drugs required by the Affordable Care Act.
	<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 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 <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 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% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Pre-certification</a> is required for some services.
	Physician/surgeon fees	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Not covered	<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 ( <a href="#">deductible</a> does not apply)			<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="#">copayment</a> /visit ( <a href="#">deductible</a> does not apply)	Not covered	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Pre-certification</a> is required.
	Physician/surgeon fees	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	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 <a href="#">copayment</a> /visit ( <a href="#">deductible</a> does not apply) Other Outpatient Services: 20% <a href="#">coinsurance</a>	Not covered	<a href="#">Pre-certification</a> is required for some services.
	Inpatient services	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Pre-certification</a> is required.

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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 <a href="#">copayment</a> /visit ( <a href="#">deductible</a> does not apply)	Not covered	Dependent daughters are not covered for this benefit.  <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Not covered	
	Childbirth/delivery facility services	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Not covered	
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="#">copayment</a> /visit	Not covered	<a href="#">Home health care</a> visits limited to 100 visits 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="#">copayment</a> /visit	Not covered	<a href="#">Pre-certification</a> is required for some services.
	<a href="#">Habilitation services</a>	0% <a href="#">coinsurance</a>	\$20 <a href="#">copayment</a> /visit	Not covered	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>	Not covered	<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>	Not covered	None.
	<a href="#">Hospice services</a>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Not covered	<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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The AVMC provider benefit applies only to provider who bills under AVMC TIN 95-6005217

## Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"><li>• Cosmetic surgery</li><li>• Dental care (Adult)</li><li>• Hearing aids</li></ul>	<ul style="list-style-type: none"><li>• Long-term care</li><li>• Non-emergency care when traveling outside the U.S.</li><li>• Infertility treatment</li></ul>	<ul style="list-style-type: none"><li>• Routine foot care</li><li>• Weight loss programs</li><li>• Routine eye care (Adult)</li></ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric surgery - (Limited to Blue Distinction Facilities only)</li></ul>	<ul style="list-style-type: none"><li>• Chiropractic Care - (Limited to 24 visits combined for chiropractic care, physical therapy, speech therapy, and occupational therapy per <a href="#">plan</a> year)</li></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing as part of home health care/hospice</li></ul>

**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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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](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: Contact Luminare Health Benefits, Inc. at 1-833-271-4121 or visit us at [www.myLuminareHealth.com](http://www.myLuminareHealth.com).

**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): 如果需要中文的帮助, 请拨打这个号码 1-833-271-4121.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-833-271-4121.

Pennsylvania Dutch (Deutsch): Fer Hilf griegie in Deutsch, 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, a'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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\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.myluminarehealth.com](http://www.myluminarehealth.com).

## 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)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist copayment</a>	\$30	■ <a href="#">Specialist copayment</a>	\$30	■ <a href="#">Specialist copayment</a>	\$30
■ Hospital (facility) <a href="#">coinsurance</a>	20%	■ Hospital (facility) <a href="#">coinsurance</a>	20%	■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%	■ Other <a href="#">coinsurance</a>	20%	■ Other <a href="#">coinsurance</a>	20%
<p>This EXAMPLE event includes services like:</p> <p><a href="#">Specialist</a> office visits (<i>prenatal care</i>)</p> <p>Childbirth/Delivery Professional Services</p> <p>Childbirth/Delivery Facility Services</p> <p><a href="#">Diagnostic tests</a> (<i>ultrasounds and blood work</i>)</p> <p><a href="#">Specialist</a> visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like:</p> <p><a href="#">Primary care physician</a> office visits (<i>including disease education</i>)</p> <p><a href="#">Diagnostic tests</a> (<i>blood work</i>)</p> <p><a href="#">Prescription drugs</a></p> <p><a href="#">Durable medical equipment</a> (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like:</p> <p><a href="#">Emergency room care</a> (<i>including medical supplies</i>)</p> <p><a href="#">Diagnostic tests</a> (<i>x-ray</i>)</p> <p><a href="#">Durable medical equipment</a> (<i>crutches</i>)</p> <p><a href="#">Rehabilitation services</a> (<i>physical therapy</i>)</p>	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Peg would pay:</b>		<b>In this example, Joe would pay:</b>		<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$500	<a href="#">Deductibles</a>	\$500	<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$10	<a href="#">Copayments</a>	\$900	<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$1,600	<a href="#">Coinsurance</a>	\$60	<a href="#">Coinsurance</a>	\$60
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$2,170</b>	<b>The total Joe would pay is</b>	<b>\$1,480</b>	<b>The total Mia would pay is</b>	<b>\$860</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.