



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, call BRMS at 1-888-259-6316. 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 1-888-259-6316 to request a copy.

Important Questions	Answers		Why This Matters:
What is the overall deductible ?	In-Network \$250/Individual \$500/Family	Out-of-Network \$500/Individual \$1,000/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 .
	Per Calendar Year		
Are there services covered before you meet your deductible ?	Yes. In-network office visits, preventive care , prescription drugs, diagnostic tests at a freestanding facility, urgent care , home health care , rehabilitation/habilitation , skilled nursing care , durable medical equipment , and hospice services .		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 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 ?	In-Network \$3,500/Individual \$7,000/Family	Out-of-Network \$6,000/Individual \$12,000/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 limit until the overall family out-of-pocket limit has been met.
	Per Calendar Year		
What is not included in the out-of-pocket limit ?	Premiums , balance billing charges, and health care this plan does not 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, visit www.Anthem.com/CA or call BRMS at 1-888-259-6316 for a list of in-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 .

 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	\$25 Copay /visit, Deductible does not apply	40% Coinsurance	Virtual and telephonic visits are the same copay as in-office visits. Telemedicine appointments are also available through Teladoc at no charge.
	Specialist visit	\$25 Copay /visit, Deductible does not apply	40% Coinsurance	None.
	Preventive care/screening/immunization	No Charge, Deductible does not apply	40% Coinsurance	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)	Freestanding Facility: \$25 Copay /visit, Deductible does not apply Outpatient Hospital: 20% Coinsurance	40% Coinsurance	None.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	40% Coinsurance	Preauthorization required. Participants are encouraged to call BRMS prior to receiving services at 1-888-259-6316.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs	Retail: No Charge, Deductible does not apply Mail Order: No Charge, Deductible does not apply	Not Covered	Coverage is subject to the prescription drug formulary. Cost sharing does not apply to ACA preventive drugs. Retail is limited to a 30-day supply. Mail-order is limited to a 90-day supply. Preauthorization , step therapy, and quantity limits may apply.
	Preferred brand drugs	Retail: \$45 Copay /prescription, Deductible does not apply Mail Order: \$50 Copay /prescription, Deductible does not apply	Not Covered	

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)	
	Non-preferred brand drugs	Retail: \$70 Copay /prescription, Deductible does not apply Mail Order: \$100 Copay /prescription, Deductible does not apply	Not Covered	Coverage is subject to the prescription drug formulary. Cost sharing does not apply to ACA preventive drugs. Retail is limited to a 30-day supply. Mail-order is limited to a 90-day supply. Specialty drugs are available through retail only and are limited to a 30-day supply. Preauthorization , step therapy, and quantity limits may apply.
	Specialty drugs	Cost share is subject to the applicable generic, preferred brand, and non-preferred brand copays above.	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	40% Coinsurance	Preauthorization required. Participants are encouraged to call BRMS prior to receiving services at 1-888-259-6316.
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	None.
If you need immediate medical attention	Emergency room care	\$150 Copay /visit, plus 20% Coinsurance	*\$150 Copay /visit, plus 20% Coinsurance	* Network deductible applies to non-network services related to a true medical emergency. Copay waived if admitted.
	Emergency medical transportation	20% Coinsurance	*20% Coinsurance	* Network deductible applies to non-network services related to a true medical emergency. Non-Emergency transport is not covered.
	Urgent care	\$35 Copay /visit, Deductible does not apply	40% Coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 Copay /visit, plus 20% Coinsurance	40% Coinsurance	Preauthorization required. Participants are encouraged to call BRMS prior to receiving services at 1-888-259-6316.
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	None.

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	Office Visit: \$25 Copay /visit, Deductible does not apply Other Outpatient Services: 20% Coinsurance	40% Coinsurance	None.
	Inpatient services	\$250 Copay /visit, plus 20% Coinsurance	40% Coinsurance	Preauthorization required. Participants are encouraged to call BRMS prior to receiving services at 1-888-259-6316.
If you are pregnant	Office visits	No Charge, Deductible does not apply	40% Coinsurance	None.
	Childbirth/delivery professional services	20% Coinsurance	40% Coinsurance	None.
	Childbirth/delivery facility services	\$250 Copay /visit, plus 20% Coinsurance	40% Coinsurance	Preauthorization required for stay exceeding 48 hours after delivery (or 96 hours after C-section). Participants are encouraged to call BRMS prior to receiving services at 1-888-259-6316.
If you need help recovering or have other special health needs	Home health care	No Charge, Deductible does not apply	40% Coinsurance	Preauthorization required. Participants are encouraged to call BRMS prior to receiving services at 1-888-259-6316. Limited to 100 visits per Calendar Year.
	Rehabilitation services	\$25 Copay /visit, Deductible does not apply	40% Coinsurance	None.
	Habilitation services	\$25 Copay /visit, Deductible does not apply	40% Coinsurance	None.
	Skilled nursing care	No Charge, Deductible does not apply	40% Coinsurance	Preauthorization required. Participants are encouraged to call BRMS prior to receiving services at 1-888-259-6316. Limited to 60 visits per Calendar Year.

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)	
	Durable medical equipment	No Charge, Deductible does not apply	40% Coinsurance	Preauthorization required if over \$500. Participants are encouraged to call BRMS prior to receiving services at 1-888-259-6316.
	Hospice services	No Charge, Deductible does not apply	40% Coinsurance	Preauthorization required. Participants are encouraged to call BRMS prior to receiving services at 1-888-259-6316.
If your child needs dental or eye care	Children's eye exam	No Charge, Deductible does not apply	40% Coinsurance	Limited to one exam per Calendar Year as part of a well-child pediatric exam.
	Children's glasses	Not Covered	Not Covered	Must enroll in a separate vision plan .
	Children's dental check-up	Not Covered	Not Covered	Must enroll in a separate dental plan .

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 • Non-emergency care when traveling outside the U.S. • Routine foot care	• Dental care (Adult) • Private duty nursing • Weight loss programs	• Long-term care • 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 (20 visits/Calendar Year combined with Chiropractic Care) • Hearing Aids (Limited to \$2,000/Calendar Year)	• Bariatric Surgery (For morbid obesity only) • Infertility Treatment	• Chiropractic Care (20 visits/Calendar Year combined with Acupuncture)

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 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: BRMS at 1-888-259-6316.

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 1-888-259-6316.

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](#) \$250
- [Specialist copayment](#) \$25
- Hospital (facility) [copay](#) + [coins.](#) \$250+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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$250
Coinsurance	\$1,900
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,460

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 copayment](#) \$25
- Hospital (facility) [copay](#) + [coins.](#) \$250+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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$1,200
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,570

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$250
- [Specialist copayment](#) \$25
- Hospital (facility) [copay](#) + [coins.](#) \$250+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	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$350
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$900

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