



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, contact the Health Benefits Department at (530) 378-8200. 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 [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call (530) 378-8200 to request a copy.

Important Questions	Answers	Why This Matters:
<a href="#">What is the overall deductible?</a>	\$250/individual or \$500/family	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> .
<a href="#">Are there services covered before you meet your deductible?</a>	Yes. <a href="#">Preventive care</a> is 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. 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> .
<a href="#">Are there other deductibles for specific services?</a>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<a href="#">What is the out-of-pocket limit for this plan?</a>	\$2,000 individual / \$4,000 family	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.
<a href="#">What is not included in the out-of-pocket limit?</a>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, 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="#">Will you pay less if you use a network provider?</a>	Yes. See <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> or call (530) 378-8200 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network 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 <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<a href="#">Do you need a referral to see a 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
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	Specialist visit	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> call (530) 378-8200	Generic drugs	20% <a href="#">coinsurance</a> (0% preventive)	Not covered	Member must submit Prescription claims to the Plan for reimbursement.
	Brand name drugs	40% <a href="#">coinsurance</a> (0% preventive)	Not covered	
	Diabetes (Wellness program)	0% <a href="#">coinsurance</a>	Not covered	
	<a href="#">Specialty drugs</a>	40% <a href="#">coinsurance</a>	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	25% penalty for Non-preferred provider hospital utilization that is not an emergency.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	25% penalty for Non-preferred provider hospital utilization that is not an emergency.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for in-patient hospitalization. 25% penalty for Non-preferred provider hospital utilization that is not an emergency.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None

[\* For more information about limitations and exceptions, see the [plan](#) or policy document.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	The only substance abuse benefits available are for employees within the EAP program.
	Inpatient services	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for in-patient hospitalization. 25% penalty for Non-preferred provider hospital utilization that is not an emergency. In-patient substance abuse services are not covered.
<b>If you are pregnant</b>	Office visits	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Maternity benefits are limited to employees and spouses.
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	18 visits/12-month. Includes restorative physical therapy, speech therapy, and occupational therapy. Registered nursing services - in lieu of hospitalization only.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
	<a href="#">Habilitation services</a>	Not covered.	Not covered.	None
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Registered skilled nursing services - in lieu of hospitalization only.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Limited to the lesser of purchase or rental of equipment on the Administrative Committee's Policy - Durable Medical Equipment.
	<a href="#">Hospice services</a>	Not covered	Not covered.	None
<b>If your child needs dental or eye care</b>	Children's eye exam	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	80% up to \$100 per Plan year
	Children's glasses	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	80% up to \$150 per Plan year
	Children's dental check-up	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	80% up to \$1,500 per Plan year

### 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](#).)**

- Alternative care
- Cosmetic surgery
- Habilitative services
- Hospice services
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care

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

- Bariatric surgery (Weight Program only)
- Chiropractic/Acupuncture care (80% of \$50/visit. 18 visits per 12-months)
- Dental care (Adult) 80% up to \$1,500/year
- Hearing aids (80% of \$500 per 36-months)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) - 80% up to \$100 for exams and up to \$150 for glasses/contacts per Plan year
- Weight Management program (employee & spouse 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](#). 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: 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). Additionally, a consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at [http://www.cms.gov/CCIIO/Resources/Consumer\\_assistance-Grants/](http://www.cms.gov/CCIIO/Resources/Consumer_assistance-Grants/).

## 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 1-800-225-5254, customer code: 99937]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-225-5254, customer code: 99937]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-225-5254, customer code: 99937]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-225-5254, customer code: 99937]

**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 <a href="#">deductible</a>	\$250
■ <a href="#">Specialist copayment</a>	\$0
■ 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
<b>In this example, Peg would pay:</b>	
Cost Sharing	
Deductibles	\$250
Copayments	\$0
Coinsurance	\$1,750
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,060

### 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 <a href="#">deductible</a>	\$250
■ <a href="#">Specialist copayment</a>	\$0
■ 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
<b>In this example, Joe would pay:</b>	
Cost Sharing	
Deductibles*	\$250
Copayments	\$0
Coinsurance	\$980
What isn't covered	
Limits or exclusions	\$230
The total Joe would pay is	\$1,460

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$250
■ <a href="#">Specialist copayment</a>	\$0
■ 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 test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
<b>In this example, Mia would pay:</b>	
Cost Sharing	
Deductibles*	\$250
Copayments	\$0
Coinsurance	\$510
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$760

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: The Health Benefits Department (530) 378-8200.

\*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.

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