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 or call (530) 378-8200 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$250/individual or $500/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.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. 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?	$2,000 individual / $4,000 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.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't 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. See www.anthem.com/ca or call (530) 378-8200 for a list of 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
		Preferred Provider (You will pay the least)	Non-Preferred 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	20% coinsurance	20% coinsurance	None
	Specialist visit	20% coinsurance	20% coinsurance	None.
	Preventive care/screening/ immunization	No charge	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)	20% coinsurance	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** call (530) 378-8200	Generic drugs	20% coinsurance (0% preventive)	Not covered	Member must submit Prescription claims to the Plan for reimbursement.
	Brand name drugs	40% coinsurance (0% preventive)	Not covered	
	Diabetes (Wellness program)	0% coinsurance	Not covered	
	Specialty drugs	40% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance	25% penalty for Non-preferred provider hospital utilization that is not an emergency.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	25% penalty for Non-preferred provider hospital utilization that is not an emergency.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	20% coinsurance	20% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	Preauthorization is required for in-patient hospitalization. 25% penalty for Non-preferred provider hospital utilization that is not an emergency.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	None.

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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	20% coinsurance	The only substance abuse benefits available are for employees within the EAP program.
	Inpatient services	20% coinsurance	20% coinsurance	Preauthorization 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.
If you are pregnant	Office visits	20% coinsurance	20% coinsurance	Cost sharing does not apply for preventive services. 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% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	18 visits/12-month. Includes restorative physical therapy, speech therapy, and occupational therapy. Registered nursing services - in lieu of hospitalization only.
	Rehabilitation services	20% coinsurance	20% coinsurance	
	Habilitation services	Not covered.	Not covered.	None
	Skilled nursing care	20% coinsurance	20% coinsurance	Registered nursing services - in lieu of hospitalization only.
	Durable medical equipment	20% coinsurance	20% coinsurance	Limited to the lesser of purchase or rental of equipment on the Administrative Committee's Policy - Durable Medical Equipment.
	Hospice services	Not covered	Not covered.	None
If your child needs dental or eye care	Children's eye exam	20% coinsurance	20% coinsurance	80% of $200/24-months
	Children's glasses	20% coinsurance	20% coinsurance	
	Children's dental check-up	20% coinsurance	20% coinsurance	80% of $1,250/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.)

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

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

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 care (80% of $50/visit. 18 visits per 12-months) • Dental care (Adult) 80% of $1,250/year	• Hearing aids (80% of $500 per 36-months) • Non-emergency care when traveling outside the U.S. • Routine eye care (Adult) 80% of $200/24-months	• Routine foot care • 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. 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. 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/.

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 plan's overall deductible** **$250**
- **Specialist copayment** **$0**
- **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	$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 plan's overall deductible** **$250**
- **Specialist copayment** **$0**
- **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*	$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 plan's overall deductible** **$250**
- **Specialist copayment** **$0**
- **Hospital (facility) coinsurance** **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**

In this example, Mia would pay:

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.