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.myLuminareHealth.com. 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 1-844-644-8349 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier I Enloe preferred provider: $0 / individual or $0 / family per benefit period. Tier II preferred provider: $250 / individual or $750 / family per benefit period. Combined with Tier III. Tier III nonpreferred provider: $250 / individual or $750 / family per benefit period. Combined with Tier II.	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. Prescription drug, benefits subject to a copay (To applicable tiers), and the following services by a preferred provider: Preventive care (Tier I and Tier II) and hospice services are covered before you meet your deductible.	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 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?	Tier I Enloe & Tier II preferred providers: $2,500 / individual or $7,500 / family per benefit period. Tier III nonpreferred provider: Unlimited. Prescription drug: $2,000 / individual or $4,000 / family per benefit period.	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.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	Penalties for failure to obtain preauthorization for services, 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 1-844-644-8349 for a list of preferred providers.	This plan uses a provider network. You pay less if you use a Tier I Enloe preferred provider in the plan's network. You will pay the most if you use a Tier II preferred provider or Tier III nonpreferred 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 nonpreferred 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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist. A referral authorization will be needed to receiving any services at a non-Enloe facility.

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 I – Enloe Preferred Provider (You will pay the least)	Tier II Preferred Provider (You will pay more)	Tier III Nonpreferred 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	$25 copay / visit deductible does not apply	20% coinsurance	None.
	Specialist visit	$25 copay / visit deductible does not apply	$25 copay / visit deductible does not apply	20% coinsurance	Chiropractic care is not covered.
	Preventive care / screening / immunization	No charge deductible does not apply	No charge deductible does not apply	20% 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.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier I – Enloe Preferred Provider (You will pay the least)	Tier II Preferred Provider (You will pay more)	Tier III Nonpreferred Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance deductible does not apply	Not covered	Not covered	Lab/cultures taken at Enloe may be sent to a non-Enloe lab for processing. If this occurs, you may call the plan administrator to have those expenses paid at Enloe benefit level.
	Imaging (CT/PET scans, MRIs)	0% coinsurance deductible does not apply	Not covered	Not covered	Imaging taken at Enloe may be sent to a non-Enloe image center for processing. If this occurs, you may call the plan administrator to have those expenses paid at Enloe benefit level. Pre-certification is required for Tier II preferred provider or Tier III nonpreferred provider. If pre-certification is not obtained, benefits are subject to a $500 penalty of the total cost of the service.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.medimpact.com or call 1-800-788-2949	Generic drugs	Enloe outpatient pharmacy: $10 copay / prescription	Preferred provider retail: $15 copay / prescription Mail order: Not covered	Nonpreferred provider retail and mail order: Not covered	Deductible does not apply. Copay applies to a 30-day supply Retail and Specialty drugs or 31-90 day supply Mail-Order prescription. Copay does not apply to preventive drugs required by the Affordable Care Act. If you purchase a brand name drug when a generic drug is available, you must pay difference in cost. MedImpact pharmacies are covered only when Enloe pharmacies are closed or for urgent non-maintenance fills.
	Preferred brand drugs	Enloe outpatient pharmacy: $25 copay / prescription	Preferred provider retail: $25 copay / prescription Preferred provider mail order: Not covered	Nonpreferred provider retail and mail order: Not covered	
	Non-preferred brand drugs	Nonpreferred provider retail and mail order: Not covered	Nonpreferred provider retail and mail order: Not covered	Nonpreferred provider retail and mail order: Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier I – Enloe Preferred Provider (You will pay the least)	Tier II Preferred Provider (You will pay more)	Tier III Nonpreferred Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.medimpact.com or call 1-800-788-2949 (continued)	Specialty drugs	Enloe outpatient pharmacy: Generic $10 copay / prescription Preferred brand: $25 copay / prescription Nonpreferred brand: Not covered	Enloe outpatient pharmacy: Generic $15 copay / prescription Preferred brand: $25 copay / prescription Nonpreferred brand: Not covered	Nonpreferred provider retail and mail order: Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance deductible does not apply	Not covered	Not covered	Pre-certification is required for some outpatient surgeries. If pre-certification is not obtained, benefits are subject to a $500 penalty of the total cost of the service.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	20% coinsurance	None.
If you need immediate medical attention	Emergency room care	$75 copay / visit deductible does not apply	Tier I Enloe preferred provider benefit applies	Tier I Enloe preferred provider benefit applies	Copay waived if admitted. The Tier III nonpreferred provider copay will accumulate to the Tier I Enloe preferred provider and Tier II preferred provider out-of-pocket limit.
	Emergency medical transportation	10% coinsurance deductible does not apply	20% coinsurance	20% coinsurance	None.
	Urgent care	$25 copay / visit deductible does not apply	$25 copay / visit deductible does not apply (Only if outside Chico)	$25 copay / visit (Only if outside Chico)	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance deductible does not apply	Not covered	Not covered	Pre-certification is required. If pre-certification is not obtained, benefits are subject to a $500 penalty of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier I – Enloe Preferred Provider (You will pay the least)	Tier II Preferred Provider (You will pay more)	Tier III Nonpreferred Provider (You will pay the most)	
If you have a hospital stay (continued)	Physician/surgeon fees	20% coinsurance	20% coinsurance	20% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not applicable for office visit and 10% coinsurance deductible does not apply for other outpatient services	$25 copay / office visit deductible does not apply and 20% coinsurance for other outpatient services	20% coinsurance	None.
	Inpatient services	10% coinsurance deductible does not apply)	20% coinsurance	20% coinsurance	Substance abuse disorders treatment is not available at Enloe. Pre-certification is required. If pre-certification is not obtained, benefits are subject to a $500 penalty of the total cost of the service.
If you are pregnant	Office visits	Not applicable	$25 copay / visit deductible does not apply	20% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copay, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	10% coinsurance deductible does not apply	Not covered	Not covered	
If you need help recovering or have other special health needs	Home health care	10% coinsurance deductible does not apply	Not covered	Not covered	Limited to 100 visits per benefit period. Pre-certification is required. If pre-certification is not obtained, benefits are subject to a $500 penalty of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier I – Enloe Preferred Provider (You will pay the least)	Tier II Preferred Provider (You will pay more)	Tier III Nonpreferred Provider (You will pay the most)	
If you need help recovering or have other special health needs (continued)	Rehabilitation services	10% coinsurance deductible does not apply)	Not covered	Not covered	Includes physical therapy, speech therapy, occupational therapy, and other rehabilitative therapies.
	Habilitation services	Not covered	Not covered	Not covered	None.
	Skilled nursing care	Not applicable	20% coinsurance	20% coinsurance	Pre-certification is required. If pre-certification is not obtained, benefits are subject to a $500 penalty of the total cost of the service.
	Durable medical equipment	10% coinsurance deductible does not apply	Not covered	Not covered	None.
	Hospice services	Inpatient and outpatient: 10% coinsurance deductible does not apply	Inpatient and outpatient: Not covered	Inpatient and outpatient: Not covered	Pre-certification is required. If pre-certification is not obtained, benefits are subject to a $500 penalty of the total cost of the service.
If your child needs dental or eye care	Children's eye exam	Not applicable	0% coinsurance deductible does not apply	20% coinsurance	Eye refraction is not covered (preventive exam only).
	Children's glasses	Not covered	Not covered	Not covered	None.
	Children's dental check-up	Not covered	Not covered	Not covered	None.

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
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

* For more information about limitations and exceptions, see the plan or policy document at www.myLuminareHealth.com.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery	• Hearing aids	•

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.

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 1-844-644-8349.
Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-844-644-8349.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-644-8349.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-844-644-8349 uff.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-644-8349.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-844-644-8349.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-844-644-8349.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-844-644-8349.

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) coinsurance	10%
Other coinsurance	10%

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	$10
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,520**

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) coinsurance	10%
Other coinsurance	10%

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	$0
Copayments	$700
Coinsurance	$80
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$800**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$250
Specialist copayment	$20
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$650**

The plan would be responsible for the other costs of these EXAMPLE covered services.