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 County of Sonoma Human Resources Department, Benefits Unit, at (707) 565-2900, or call Anthem at (855) 333-5730. 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 (855) 333-5730 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500/member or $1,500/family for In-Network Providers.	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, Primary Care visit, Specialist visit, mental/behavioral health or substance use disorder office visit, and Urgent Care for In-Network Providers. Outpatient prescription drugs.	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. There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For Medical Plan: $5,500/member or $11,500/family for In-Network Providers. For outpatient prescription drugs: $1,100/member or $1,700/family. All Providers.	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?	For Medical Plan: Premiums, balance-billing charges, outpatient prescription drugs, penalties for failure to obtain preauthorization, and health care this plan doesn't cover. For outpatient prescription drugs: Premiums, balance-billing charges, penalties for failure to obtain preauthorization, medical plan expenses, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes, EPO. See www.anthem.com/ca or call (855) 333-5730 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
		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	$50 copayment/visit deductible does not apply	Not covered	None
	Specialist visit	$50 copayment/visit deductible does not apply	Not covered	None
	Preventive care/screening/ immunization	No charge, deductible does not apply	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	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	Preauthorization of certain imaging tests is required to avoid a financial penalty.

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 drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com or call 1-800-966-5772.	Generic	Retail pharmacy for 34-day supply: $10 copayment / prescription; Mail Order for 90-day supply: $20 copayment / prescription. No charge for FDA-approved generic contraceptives.	If you fill a prescription at an Out-of-Network pharmacy, you pay 100% for the drug at the time of purchase and file a claim with Caremark for reimbursement and Plan reimburses no more than it would have paid had you used a network pharmacy.	• Deductible does not apply. • You pay the lesser of the copayment or the drug cost. • Some prescription drugs are subject to preauthorization (to avoid non-payment), quantity limits or step therapy requirements. • The Plan provides a mandatory generic program meaning that if a brand name drug is dispensed in place of a generic, regardless of whether you or your doctor request it, you will pay the brand copayment plus the difference in cost between the generic and brand name drug. • Certain over-the-counter (OTC) and prescription drugs are payable at no charge with a prescription.
	Preferred / Brand	Retail pharmacy for 34-day supply: $35 copayment / prescription; Mail Order for 90-day supply: $70 copayment / prescription. No charge for FDA-approved brand name contraceptive if a generic is medically inappropriate or unavailable.		
	Non-Preferred	Retail pharmacy for 34-day supply: $70 copayment / prescription; Mail Order for 90-day supply: $140 copayment / prescription.		
	Specialty	You pay the same copayment as applies above for Generic, Preferred Brand and Non-preferred brand drugs.	Specialty drugs not covered if obtained from an Out-of-Network non-PPO retail or mail order pharmacy.	Specialty drugs require preauthorization (to avoid non-payment) by calling Caremark at 1-800-237-2767.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$500 copayment / visit plus 20% coinsurance	Not covered	None
	Physician/ surgeon fees	20% coinsurance	Not covered	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 immediate medical attention	Emergency room care	$150 copayment/visit plus 20% coinsurance	$150 copayment/visit plus 20% coinsurance	If admitted, ER copayment is waived. 20% coinsurance for Emergency Room Physician Fee. Non-emergency use of an out-of-network emergency room is not covered.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$50 copayment/visit deductible does not apply	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copayment/ admission plus 20% coinsurance	Not covered	Elective hospital admission, bariatric surgery and transplant services require preauthorization to avoid a financial penalty.
	Physician/ surgeon fees	20% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit $50 copayment / visit deductible does not apply Other Outpatient 20% coinsurance	Not covered	None
	Inpatient services	$500 copayment / admission plus 20% coinsurance	Not covered	Elective hospital admission and residential treatment facility admission requires preauthorization to avoid a financial penalty. 20% coinsurance for Inpatient Physician Fee In-Network Providers. No coverage for Inpatient Physician Fee Out-of-Network Providers.
If you are pregnant	Office visits	No charge, deductible does not apply	Not covered	• Cost sharing does not apply for preventive services. • Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). • Prenatal care (other than In-Network office visits and ACA-required preventive screenings) is not covered for dependent children. • Preauthorization is required to avoid a financial penalty only if hospital stay is longer than 48 hours for vaginal delivery or 96 hours for C-section.
	Childbirth delivery professional services	20% coinsurance	Not covered	
	Childbirth delivery facility services	$250 copayment / admission plus 20% coinsurance	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)	
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	You pay 100% of this service, even In-Network.
	Rehabilitation services	Outpatient: 20% coinsurance Inpatient: $500 copayment / admission plus 20% coinsurance	Not covered	Preauthorization of inpatient rehabilitation admission is required to avoid a financial penalty.
	Habilitation services	20% coinsurance	Not covered	None.
	Skilled nursing care	Not covered	Not covered	You pay 100% of this service, even In-Network.
	Durable medical equipment	20% coinsurance	Not covered	While breastfeeding, no charge from In-network providers for breastfeeding pump and supplies needed to operate the pump.
	Hospice services	20% coinsurance	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge, deductible does not apply when obtained during preventive care office visit.	Not covered	If you elect additional vision coverage it will be available under a separate vision plan.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	If you elect dental coverage it will be available under 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
- Dental care (Adult and Child) (unless you elect Dental coverage)
- Glasses for a child
- Home Health care
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care unless you have been diagnosed with diabetes
- Skilled nursing care
- Weight loss programs (except as required by health reform law)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Abortion • Acupuncture	• Bariatric Surgery • Chiropractic care	• Hearing aids (one hearing aid/ear every three years) • Infertility treatment is covered for diagnosis and surgical repair

Your Rights to Continue Coverage: There are agencies that can help if you if you want to continue your coverage after it ends. The contact information for these agencies is: the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x 61565 or 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 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 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 County of Sonoma Human Resources Department, Benefits Unit, at (707) 565-2900; or Anthem at: ATTN: Grievances and Appeals, P.O. Box 4310, Woodland Hills, CA 91365-4310

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 (855) 333-5730.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (855) 333-5730.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 (855) 333-5730.

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	$500
Specialist copayment	$50
Hospital (facility) copayment	$250
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	$12,800

In this example, Peg would pay:

Cost sharing	
Deductibles	$500
Copayments	$280
Coinsurance	$2,140
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	$2,930

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Specialist copayment	$50
Hospital (facility) copayment	$500
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	$7,400

In this example, Joe would pay:

Cost sharing	
Deductibles	$190
Copayments	$1,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$210
The total Joe would pay is	$1,900

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

The plan's overall deductible	$500
Specialist copayment	$50
Hospital (facility) ER copayment	$150
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	$1,900

In this example, Mia would pay:

Cost sharing	
Deductibles	$500
Copayments	$340
Coinsurance	$190
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,030

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