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 HealthComp LLC at 1-800-442-7247. 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 1-800-442-7247 to request a copy.

Important Questions	Answers		Why This Matters:
What is the overall deductible?	**Network** *Per Calendar Year* $150/Individual $300/Family	**Out-of-Network** *Per Calendar Year* $750/Individual $1,500/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. Prescription drugs, emergency care, first $5,000 for ambulance service, network Preventive care and other services as described in your plan document 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 deductible for specific services.
What is the out-of-pocket limit for this plan?	Medical / Prescription **Network** *Per Calendar Year* $1,500/Individual $3,000/Family	**Out-of-Network** Unlimited	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.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.anthem.com/ca or call 1-800-442-7247 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	$20/visit Deductible waived	40% coinsurance	None
	Specialist visit	$40/visit Deductible waived	40% coinsurance	None
	Preventive care/screening/ immunization	No charge Deductible waived	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)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Precertification may be required for certain services. If you don't get precertification, benefits could be reduced.

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.envisionrx.com	Generic drugs	**Retail & Mail order** $10/prescription	Not covered	Retail is limited to a 30-day supply. Mail order is limited to a 90-day supply.
	Preferred brand drugs	**Retail & Mail order** $15/prescription	Not covered	
	Non-preferred brand drugs	**Retail & Mail order** $35/prescription	Not covered	
	Specialty drugs	**Retail & Mail order** $35/prescription	Not covered	San Jose Unified School District has partnered with Elixir to develop a specialty pharmacy program that provides savings for employees and their family members, as well as reduce overall medication costs in several key drug categories. The program is fully supported by the team of customer care experts at Elixir Specialty Pharmacy. Your out of pocket expense for each specialty prescription will remain in the range of $0-$35 per fill for the duration of the program. Please call Elixir Specialty Pharmacy at 1-833-478-6373, to enroll 24 hours a day, seven days a week.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Precertification may be required for certain services. If you don't get precertification, benefits could be reduced.
	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 immediate medical attention	Emergency room care	**Emergency** $75/visit + 20% coinsurance Deductible waived **Non-emergency** $50/visit + 20% coinsurance		Copayment waived if admitted.
	Emergency medical transportation	20% coinsurance		No charge for first $5,000.
	Urgent care	$15/visit Deductible waived	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$250/admission 20% coinsurance	$250/admission 40% coinsurance	Precertification is required. If you don't get precertification, benefits could be reduced.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office benefit 20% coinsurance	40% coinsurance	Precertification may be required for facility services. If you don't get precertification, benefits could be reduced.
	Inpatient services	$250/admission 20% coinsurance	$250/admission 40% coinsurance	Precertification is required. If you don't get precertification, benefits could be reduced.
If you are pregnant	Office visits	No charge Deductible waived	40% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	**Newborn Care Circumcision** Not covered **Other** 20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	$250/admission 20% coinsurance	$250/admission 40% coinsurance	Precertification is only required for stay exceeding 48 hours after delivery (or 96 hours after C-section). If you don't get precertification when required, benefits could be reduced.

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	20% coinsurance	40% coinsurance	Limited to 60 visits every 12 months. Precertification is required. If you don't get precertification, benefits could be reduced.
	Rehabilitation services	$20/visit Deductible waived	40% coinsurance	Includes Physical, Speech, and Occupational Therapies in office and outpatient facility settings.
	Habilitation services	$20/visit Deductible waived	40% coinsurance	Applied Behavior Analysis Therapy is 20% coinsurance Network and 40% Out-of-Network.
	Skilled nursing care	20% coinsurance	40% coinsurance	A three-day hospital stay is required prior to admission. Precertification is required. If you don't get precertification, benefits could be reduced.
	Durable medical equipment	20% coinsurance	40% coinsurance	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. Precertification may be required for certain services. If you don't get precertification, benefits could be reduced.
	Hospice services	20% coinsurance	40% coinsurance	Precertification may be required for certain services. If you don't get precertification, benefits could be reduced.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	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.)

- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

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

- Acupuncture (Physician referral is required)
- Bariatric Surgery (only if life threatening condition)
- Chiropractic Care (Limited to 40 visits per Calendar Year)
- Private Duty Nursing

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: San Jose Unified School District at 1-408-535-6139, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 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 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: HealthComp LLC at 1-800-442-7247 or 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 1-800-442-7247.

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** **$150**
- **Specialist coinsurance** **$40**
- **Hospital(facility)copay+coinsurance** **$250+20%**
- **Other (Tests) 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	$150
Copayments	$300
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,560**

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

- **The plan's overall deductible** **$150**
- **Specialist copayment** **$40**
- **Hospital(facility)copay+coinsurance** **$250+20%**
- **Other (Brand drugs) copayment** **$15**

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	$150
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,020**

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

- **The plan's overall deductible** **$150**
- **Specialist copayment** **$40**
- **Hospital (ER) copay+coinsurance** **$75+20%**
- **Other (Physical Therapy) copayment** **$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	$150
Copayments	$400
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$850**

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