
 D77 naa 1hly3 d00 bee n7k1 1'doolwo[7g77 benefits and coverage (SBC) naaltsoos bik11'7g77 47 binahj8' bik'ehgo naa 1hly32doo, plan, n1 hasht'e dooln77[. SBC 47 ni d00 plan bi[a[ch'ishd66' 1k1 i'iilyeed b33h da'717n7g77 bik'4 ni'iily4edoo7g77 baa hane'. !{TS\$: B4eso 1ch'33h naa'nil bee naa 1hly32doo7g77 bik'4 nihely4, (premium a[d0' woly4) 47 t'11 sahdii baa hodoonih. D77 47 t'00 ch'7'7t'32go hane' 1t'4. Hane' t'11 1t'4 naa 1hly32doo baa hodoonih, 47 doodago naaltsoos bee shaa doo'ni[jin7zingo 47 kwe'4 na'7d7d77[ki[[Health Benefits Department (530) 378-8200. Saad chodaa'7n7n7g77, allowed amount, balance billing, coinsurance, copayment, deductible, provider 47 doodago saad biyaa da'7dzo 47d7 47 naaltsoos7g77 Glossary woly4, 47 11h ha'n7n7g77 dabik11. Glossary 47 kwe'4. www.healthcare.gov/sbc-glossary haji[ki' 1ld00 koj8' hod77lnih (530) 378-8200 1ko hach'8' ldooln77[.

Na'7d7kid danil7n7g77	Na'7d44kid N1't33' Baa Hane'	Ha'1t'77 biniinaa d77 ho[b44h0zingo y1'1't44h?
Deductible t'11 1t'4gosh d7kw77 nijil44h? ?	\$250/individual or \$500/family	Azee'77['7n7 providers h1k1 an7daalwo'go b33h da'az199'7g77 deductible b7ighah yileehj8' a[tso nijil44hd00 7nda d77 plan ni'iil4 yileeh. [Haa 1hly3 ha'1[ch7n7 bi[haghanii bik'4sti'7g77 47 instructions, plan choo'9 y7na'ni[tindi saad b1 dahsijaa'.]
Deductible t'ahdoo b7ighah ni'j7144g00 daats'7 1k1 an1'1lwo' haa 1hly3 b7k'4sti'7g77 h01=?	Aoo'. Preventive care	D77 plan 47 azh3 deductible t'ahdoo a[tso b7ighah nij714eda nidi bee haa 1hlyln7g77 d00 h1k1 an1'1lwo', services, [a' t'11 bik'4sti'. !kondi copayment d00 coinsurance [ahd00 bik'4 nijiil4h7g77 47 t'11 1k0t'4eda doo. [Bik'ehgo aa'1hlyln7g77, plan, lniid [ahgo llyaii bik'ee'aan ah00t'i'7g77 47 k0t'4ego saad biih doodzoh: "T'00 bee hane'go, d77 bik'ehgo naa 1hlyln7g77, plan, 47 at'77s y22h dahwiidoo['aa[ii bich'33h haa 1hly3, preventive services haash99 daat'4h7g77 bik'4sti'go 4id7 47 [ahd00 t'11 h0 ni'jiil4h7g77, cost sharing doo h01=-da d00 deductible a[d0' t'ladoo nij714h4 1k0t'4. Ats'77s y22h dahwiidoo['aa[ii bi'ch'33h haa 1hly3, preventive services, hak'4sti'ii naaltsoos dabik11' 47 kwe'4 yaa halne' https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Ak1 i'iilyeed daats'7 [a' t'11 sahdii deductible b1 h01=-go haa n4elt'e'?	Dooda.	Ts'7d1 1k1 an1'1lwo'7g77 47 doo bik'ehgo deductibles nihely4eda.
D77 shib4eso [ahd00 nihes[4h7g77 out-of-pocket limit 47 plan haa n4elt'e'j8'yee has'3??	\$2,000/individual or \$4,000/family	Haa 1hlyln7g77 bik'ehgo t'11[1'7 n11haij8' h1k1 an1'1lwo'go b33h nida'iileeh7g77 ts'7d1 atisdi 1n4elt'e' nizhdool4e[go beehaz'1n7g77 47 Ooly4 out-of-pocket limit. [Haa 1hly3 ha'1[ch7n7 bi[haghanii bik'4sti'7g77, plan choo'9 y7na'ni[tindi saad b1 dahsijaa'.

Ha'lt'7i 47 out-of-pocket limit, doo bi[0lta'da??	Premiums , balance-billing charges, and health care this plan doesn't cover.	D77 bik'4 ni'jiizla'7g77, 47 doo out-of-pocket limit w0lta'7j7 bi[0lta'da.
Azee'77['7n7 bi[aha'dee'tln7g77 choo'98go daats'7 doo [3 nijiil4eda?	Aoo'.. See www.anthem.com/ca or call (530) 378-8200 for a list of network providers .	D77 bik'ehgo haa 1hlyln7g77 plan 47 azee'77['7n7 b1 nidaalnish7g77, provider network chodayoo['9. Azee'77['7n7, provider, plan y1 nidaalnish7g77 chojoo['98go 47 t'11 a'ohgo bik'4 nijiil4. Azee'77['7n7 plan doo y1 naalnish7g77 out-of-network provider 47 [3 bik'4 nijil44h, d00 azee'77['7n7 provider yik'4 naashnish7g77 plan bee haa 1hlyln7d66' yik'4 as[1h7g77 billahdi 1n4elt'e' naah h1l['1 n7igo 7'iilaago 47 (balance billing) lyiilaadoo. Baa lko n7n7zindoo, azee'77[7n7 plan nih7gii y1 naalnish7g77 network provider 47 n1ln1 [a' azee'77['7n7 plan doo y1 naalish7g77 out-of-network provider yidoo['aa[(ats'77s naalkaahda biniy4). Ne'azee'77['7n7 provider nab7d7d77[ki[t'ladoo 1k0n4he
Naaltsoos, referral, h0l=-go0sh 47 specialist h1k1 adoolwo[??	Dooda.	Azee'77['7n7 t'11 [1h1go ats'77s yinaalnish7g77 specialist bich'8' jidoog11[naaltsoos, referral t'1lg44d nidi..

 [Copayment](#) d00 [coinsurance](#) nihely4 d77 naaltsoos bik11'7g77 47 [deductible](#) a[tso b7ighahgo nijil44hd00 nijiil4, [deductible](#) h0l==d33'.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
Released on April 6, 2016

Biniy4 azee'77['7n7 bich'8' jigh11h7g77	!k1 an1'alwo' choid77['88[7g77	D77 bik Azee'77['7 bi[a[ha'deet'1n7g77 (A'ohgo nid77144[)	bi[a[ha'deet'1n7g77 ([3 nid77144[)	hoo'aah doo7g77
Azee'77['7n7 bich'8' a[n11j7d1ahgo	T7dinilyaago 47 doodago nitah doo h00ts'77dg00 hwe'azee'77['7n7 h1k1 iilwo'	20% coinsurance	20% coinsurance	Dooda
	Azee'77['7n7 Specialist hon44['99'	20% coinsurance	20% coinsurance	Dooda
	@ahdahwiidoo['aa[ii bik'ij8' haa 1hly32go Preventive care/screening/immunization	Dooda ah-tah-gi-jah	Dooda ah-tah-gi-jah	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for.
Hats'77s naalkaah	Hats'77s naalkaah Diagnostic test	20% coinsurance	20% coinsurance	Dooda

Biniy4 azee'77['7n7 bich'8' jigh11h7g77	!k1 an1'alwo' choid77['88[7g77	D77 bik'4 ni'd77144[K0n7zahj8' beehaz'3 d00 bee h1 hoo'aah doo7g77
		Azee'77['7 bi[a[ha'deet'1n7g77 (A'ohgo nid77144[)	Azee'77['7n7 doo bi[a[ha'deet'1n7g77 ({3 nid77144[)	
	(Agh1'd71dlaad, hadi[naalkaah)			
	Agh1'd71dlaad hats'77s bee n41'9 (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	Dooda
Azee' bee y2'2t'44h jidoolee[ii chojoo'9, prescription drug coverage 47 kwe'4 baa hane' (530) 378- 8200	Azee' Generic dei[n7igo a'ohgo b33h717n7g77	20% coinsurance (retail & mail order)	Dooda	Prescription receipt must be submitted to the Plan for reimbursement.
	Azee' b7zhi' ldaalyaa, brand name dei[n7igo d00 7iyis77 choo'7n7g77, preferred brand drugs,a[d0' dei[n7	40% coinsurance (retail & mail order)	Dooda	Prescription receipt must be submitted to the Plan for reimbursement.
	Azee' b7zhi' ldaalyaa, brand name dei[n7n7g77 d00 doo ay0o choo'7n7g77, non- preferred dei[n7	40% coinsurance (retail & mail order)	Dooda	Prescription receipt must be submitted to the Plan for reimbursement.
	Azee' t'11 [1h1go haz'3 bich'8' azee' llyaa7g77, <u>specialty drug</u> dei[n7n7g77	40% coinsurance	Dooda	Prescription receipt must be submitted to the Plan for reimbursement.
Azee'1['98gi doo yah aj77ylada nidi naho'dishgizh	Azee' 11'98gi bee na'anish7 d00 ha'1t'7ida chodaa'7n7g77 bik'4 i'ii'n77[(azee'11'98gi na'algizh t'47 biniy4 n7da'	20% coinsurance	20% coinsurance	Preauthorization is required.

[* For more information about limitations and exceptions, see your Plan Document/Summary Plan Description.]

Biniy4 azee'77['7n7 bich'8' jigh11h7g77	!k1 an1'alwo' choid77['88[7g77	D77 bik'4 ni'd77144[K0n7zahj8' beehaz'3 d00 bee h1 hoo'aah doo7g77
		Azee'77['7 bi[a[ha'deet'1n7g77 (A'ohgo nid77144[)	Azee'77['7n7 doo bi[a[ha'deet'1n7g77 ({3 nid77144[)	
	aldahgi, ambulatory surgery center) Azee'77['7n7/nida'a [gizh7g77 b4eso yik'4 naashnish7g77	20% coinsurance	20% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance , 25% penalty	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	20% coinsurance	Substance abuse treatment not covered.
	Inpatient services	20% coinsurance	20% coinsurance , 25% penalty	Preauthorization is required. Substance abuse treatment not covered.
If you are pregnant	Office visits	20% coinsurance	20% coinsurance	Limited to employees and spouses. Cost sharing does not apply to certain preventive services . Depending on the type of services, coinsurance may apply.
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	Limited to employees and spouses.
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance , 25% penalty	Limited to employees and spouses.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Registered nurses only. In Lieu of hospitalization only.
	Rehabilitation services	20% coinsurance	20% coinsurance	18 visits/12 month limit
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	20% coinsurance	20% coinsurance	Registered nurses only. In Lieu of hospitalization.
	Durable medical equipment	20% coinsurance	20% coinsurance	Limited to DME on policy list.

[* For more information about limitations and exceptions, see your Plan Document/Summary Plan Description.]

Biniy4 azee' 77 ['7n7 bich' 8' jigh11h7g77	!k1 an1' alwo' choid77 ['88 [7g77	D77 bik' 4 ni' d77144 [K0n7zahj8' beehaz' 3 d00 bee h1 hoo' aah doo7g77
		Azee' 77 ['7 bi [a [ha' deet' 1n7g77 (A' ohgo nid77144 [)	Azee' 77 ['7n7 doo bi [a [ha' deet' 1n7g77 ({3 nid77144 [)	
	Hospice services	Not covered	Not covered	Not covered
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 \$1250/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 .)		
<ul style="list-style-type: none"> Acupuncture Cosmetic surgery 	<ul style="list-style-type: none"> Infertility treatment Long-term care 	<ul style="list-style-type: none"> Private-duty nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> Bariatric surgery (Weight Management Program) Chiropractic care Dental care (Adult) 	<ul style="list-style-type: none"> Hearing aids Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> Routine eye care (Adult) Routine foot care (excludes orthotics) Weight loss program

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: the 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 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: the 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](#). Contact the California Consumer Assistance Program operated by the California Department of Managed Health Care and Department of Insurance, at (888) 466-2219 or <http://www.healthhelp.ca.gov>. A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthreform and <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>.

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 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, kwijigo 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.

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 coinsurance](#) 20%
- [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	\$12,800
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$0
Coinsurance	\$1,750
<i>What isn't covered</i>	
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 coinsurance](#) 20%
- [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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$0
Coinsurance	\$1,750
<i>What isn't covered</i>	
Limits or exclusions	\$500
The total Joe would pay is	\$2,500

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

- The [plan's](#) overall [deductible](#) \$250
- [Specialist coinsurance](#) 20%
- [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	\$1,900
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$0
Coinsurance	\$30
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$280

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.