



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/](http://www.healthcare.gov/sbc-glossary/) or call (855) 333-5730 to request a copy.

Important Questions	Answers	Why This Matters:
<p><b>What is the overall <a href="#">deductible</a>?</b></p>	<p><b>\$500/member or \$1,500/family for In-<a href="#">Network Providers</a>.</b></p>	<p>Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>
<p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>	<p>Yes. <a href="#">Preventive care</a>, Primary Care visit, <a href="#">Specialist</a> visit, mental/behavioral health or substance use disorder office visit, LiveHealth Online, and <a href="#">Urgent Care</a> for In-<a href="#">Network Providers</a>. Outpatient <a href="#">prescription drugs</a>.</p>	<p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain preventive services without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a>. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p><b>Are there other <a href="#">deductibles</a> for specific services?</b></p>	<p>No. There are no other specific <a href="#">deductibles</a>.</p>	<p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>
<p><b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b></p>	<p><b>For Medical Plan: \$5,500/member or \$11,500/family for In-<a href="#">Network Providers</a>. For outpatient <a href="#">prescription drugs</a>: \$1,100/member or \$1,700/family. All <a href="#">Providers</a>.</b></p>	<p>The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a>, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.</p>
<p><b>What is not included in the <a href="#">out-of-pocket limit</a>?</b></p>	<p><b>For Medical Plan: <a href="#">Premiums</a>, <a href="#">balance-billing</a> charges, outpatient <a href="#">prescription drugs</a>, penalties for failure to obtain <a href="#">preauthorization</a>, and health care this <a href="#">plan</a> doesn't cover. For outpatient <a href="#">prescription drugs</a>: <a href="#">Premiums</a>, <a href="#">balance-billing</a> charges, penalties for failure to obtain <a href="#">preauthorization</a>, medical plan expenses, and health care this <a href="#">plan</a> doesn't cover.</b></p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <a href="#">network provider</a> ?	Yes, EPO. See <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> or call (855) 333-5730 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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
		<a href="#">Network Provider</a> (You will pay the least)	<a href="#">Out-of-Network Provider</a> (You will pay the most)	
If you visit a <a href="#">health care provider's</a> office or clinic	Primary care visit to treat an injury or illness	LiveHealth Online: \$10 <a href="#">copayment</a> /visit, <a href="#">deductible</a> does not apply All other: \$50 <a href="#">copayment</a> /visit <a href="#">deductible</a> does not apply	Not covered	None
	<a href="#">Specialist</a> visit	LiveHealth Online: \$10 <a href="#">copayment</a> /visit, <a href="#">deductible</a> does not apply All other: \$50 <a href="#">copayment</a> /visit <a href="#">deductible</a> does not apply	Not covered	None
	<a href="#">Preventive care/screening/immunization</a>	No charge, <a href="#">deductible</a> does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> 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)	
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a> or call 1-800-966-5772.</p>	Generic	Retail pharmacy for 34-day supply: \$10 <a href="#">copayment</a> / prescription; Mail Order for 90-day supply: \$20 <a href="#">copayment</a> / prescription. No charge for ACA required generic preventive drugs (such as contraceptives).	<p>If you fill a prescription at an Out-of-<a href="#">Network</a> pharmacy, you pay 100% for the drug at the time of purchase and file a claim with Caremark for reimbursement and <a href="#">Plan</a> reimburses no more than it would have paid had you used a <a href="#">network</a> pharmacy.</p>	<ul style="list-style-type: none"> <li>• <a href="#">Deductible</a> does not apply.</li> <li>• You pay the lesser of the <a href="#">copayment</a> or the drug cost.</li> <li>• Some <a href="#">prescription drugs</a> are subject to <a href="#">preauthorization</a> (to avoid non-payment), quantity limits or step therapy requirements.</li> <li>• The <a href="#">Plan</a> 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 <a href="#">copayment</a> plus the difference in cost between the generic and brand name drug.</li> <li>• Certain over-the-counter (OTC) and <a href="#">prescription drugs</a> are payable at no charge with a prescription.</li> </ul>
	<a href="#">Preferred/Brand</a>	Retail pharmacy for 34-day supply: \$35 <a href="#">copayment</a> / prescription; Mail Order for 90-day supply: \$70 <a href="#">copayment</a> / prescription. No charge for ACA required brand name preventive drugs if a generic is medically inappropriate or unavailable.		
	Non- <a href="#">Preferred</a>	Retail pharmacy for 34-day supply: \$70 <a href="#">copayment</a> / prescription; Mail Order for 90-day supply: \$140 <a href="#">copayment</a> / prescription.		
	<a href="#">Specialty</a>	You pay the same <a href="#">copayment</a> as applies above for Generic, Preferred Brand and Non-preferred brand drugs.	<a href="#">Specialty drugs</a> not covered if obtained from an Out-of- <a href="#">Network</a> non-PPO retail or mail order pharmacy.	
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	\$500 <a href="#">copayment</a> / visit plus 20% <a href="#">coinsurance</a>	Not covered	None
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	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	<a href="#">Emergency room care</a>	\$150 <a href="#">copayment</a> /visit plus 20% <a href="#">coinsurance</a>	\$150 <a href="#">copayment</a> /visit plus 20% <a href="#">coinsurance</a>	If admitted, ER <a href="#">copayment</a> is waived. 20% <a href="#">coinsurance</a> for Emergency Room Physician Fee. Non-emergency use of an out-of- <a href="#">network</a> emergency room is not covered.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	\$50 <a href="#">copayment</a> /visit <a href="#">deductible</a> does not apply	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 <a href="#">copayment</a> / admission plus 20% <a href="#">coinsurance</a>	Not covered	Elective hospital admission, bariatric surgery and transplant services require <a href="#">preauthorization</a> to avoid a financial penalty.
	Physician/ surgeon fees	20% <a href="#">coinsurance</a>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	LiveHealth Online: \$10 <a href="#">copayment</a> /visit, <a href="#">deductible</a> does not apply Office Visit \$50 <a href="#">copayment</a> / visit <a href="#">deductible</a> does not apply Other Outpatient 20% <a href="#">coinsurance</a>	Not covered	None
	Inpatient services	\$500 <a href="#">copayment</a> / admission plus 20% <a href="#">coinsurance</a>	Not covered	Elective hospital admission and residential treatment facility admission requires <a href="#">preauthorization</a> to avoid a financial penalty. 20% <a href="#">coinsurance</a> for Inpatient Physician Fee In- <a href="#">Network Providers</a> . No coverage for Inpatient Physician Fee <a href="#">Out-of-Network Providers</a> .
If you are pregnant	Office visits	No charge, <a href="#">deductible</a> does not apply	Not covered	<ul style="list-style-type: none"> <li><a href="#">Cost sharing</a> does not apply for preventive services.</li> <li>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).</li> <li>Prenatal care (other than In-<a href="#">Network</a> office visits and ACA-required preventive <a href="#">screenings</a>) <b>is not covered for dependent children.</b></li> <li><a href="#">Preauthorization</a> 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.</li> </ul>
	Childbirth delivery professional services	20% <a href="#">coinsurance</a>	Not covered	
	Childbirth delivery facility services	\$250 <a href="#">copayment</a> / admission plus 20% <a href="#">coinsurance</a>	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	<a href="#">Home health care</a>	Not covered	Not covered	You pay 100% of this service, even <a href="#">In-Network</a> .
	<a href="#">Rehabilitation services</a>	Outpatient: 20% <a href="#">coinsurance</a> Inpatient: \$500 <a href="#">copayment</a> / admission plus 20% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> of inpatient rehabilitation admission is required to avoid a financial penalty.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	Not covered	None.
	<a href="#">Skilled nursing care</a>	Not covered	Not covered	You pay 100% of this service, even <a href="#">In-Network</a> .
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	Not covered	While breastfeeding, no charge from <a href="#">In-network providers</a> for breastfeeding pump and supplies needed to operate the pump.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge, <a href="#">deductible</a> does not apply when obtained during <a href="#">preventive care</a> office visit.	Not covered	If you elect additional vision coverage it will be available under a separate vision <a href="#">plan</a> .
	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 <a href="#">plan</a> .

### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult and Child) (unless you elect Dental coverage)</li> <li>• Glasses for a child</li> <li>• <a href="#">Home health care</a></li> <li>• Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private-duty nursing</li> <li>• Routine eye care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot care unless you have been diagnosed with diabetes</li> <li>• <a href="#">Skilled nursing care</a></li> <li>• Weight loss programs (except as required by health reform law)</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Abortion</li> <li>• Acupuncture</li> </ul>	<ul style="list-style-type: none"> <li>• Bariatric Surgery</li> <li>• Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids (one hearing aid/ear every three years)</li> <li>• Infertility treatment is covered for diagnosis and surgical repair</li> </ul>

**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 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](http://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](http://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 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**

[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 (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.

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*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 <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$50
■ Hospital (facility) <u>copayment</u>	\$250
■ Other <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$260
<u>Coinsurance</u>	\$2,080
<u>What isn't covered</u>	
Limits or exclusions	\$20
<b>The total Peg would pay is</b>	<b>\$2,860</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$50
■ Hospital (facility) <u>copayment</u>	\$500
■ Other <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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#### In this example, Joe would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$140
<u>Copayments</u>	\$1,410
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$90
<b>The total Joe would pay is</b>	<b>\$1,640</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist copayment</u>	\$50
■ Hospital (facility) ER <u>copayment</u>	\$150
■ Other <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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#### In this example, Mia would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$350
<u>Coinsurance</u>	\$350
<u>What isn't covered</u>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,200</b>

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