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, 1-866-730-8588. 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.vbas.com or call 1-866-730-8588 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	N/A	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes	See the chart starting on page 2 for costs for services this plan covers.
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?	$2,000 single / $4,000 family Pharmacy Maximum $5,125/person, $7,300/family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Non- covered services, cost containment penalties and copayments. Certain specialty pharmacy drugs are considered non-essential health benefits and fall outside the out-of-pocket limits. The cost of these drugs (though reimbursed by the manufacturer at no cost to you) will not be applied towards satisfying your out-of-pocket maximums	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**. Non-Essential specialty pharmacy drugs: even though you incur these expenses, they don't count toward the out-of-pocket limit.

Will you pay less if you use a network provider?	This plan uses the Anthem Provider Network, for a list of In-Network providers, see www.anthem.com/ca	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. You do not have coverage for services provided out-of-network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do you need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.

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 copayment	Not Covered	None
	Specialist visit	$20 copayment	Not Covered	None
	Preventive care/screening/ immunization	$0 copayment	Not Covered	As recommended by the United States Preventative Services Task Force.
If you have a test	Diagnostic test (x-ray, blood work)	$0 copayment	Not Covered	None
	Imaging (CT/PET scans, MRIs)	$100 copayment per test	Not Covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.express-scripts.com	Generic drugs	$7 copayment retail/ $14 copayment mail-order	$7 copayment retail/ $14 copayment mail-order	Female Oral Contraceptives (Generic) have no copayment for retail & mail order. Covers up to a 34 day supply (retail) or 90 day supply (mail order or Smart90).
	Formulary brand drugs	$25 copayment retail/ $50 copayment mail-order	$25 copayment retail/ $50 copayment mail-order	Covers up to a 34 day supply (retail) or 90 day supply (mail order or Smart90).
	Non-Formulary brand drugs	$50 copayment retail/ $100 copayment mail-order	$50 copayment retail/ $100 copayment mail-order	Covers up to a 34 day supply (retail) or 90 day supply (mail order or Smart90).
	Specialty Drugs	Subject to the applicable copayment as Generic, Formulary or Non-Formulary.	Not Covered	Covers 34 - 90 day supply through Accredo Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$0 copayment	Not Covered	Pre-certification may be required.
	Physician/surgeon fees	$0 copayment	Not Covered	None
If you need immediate medical attention	Emergency room care	$150 copayment	Covered as In-Network	Copayment waived if admitted.
	Emergency medical transportation	$0 copayment	Covered as In-Network	None
	Urgent care	$20 copayment	Covered as In-Network	Copayment waived if admitted.

If you have a hospital stay	Facility fee (e.g., hospital room)	$0 copayment	Not Covered	Pre-certification required.
	Physician/surgeon fees	$0 copayment	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copayment; Facility Charges No Cost Share	Not Covered	None
	Inpatient services	$0 copayment	Not Covered	Pre-certification required.
If you are pregnant	Office visits	$20 copayment	Not Covered	None
	Childbirth/delivery professional services	$0 copayment	Not Covered	None
	Childbirth/delivery facility services	$0 copayment	Not Covered	Pre-certification required if stay exceeds 48 hours following a normal vaginal delivery, or 96 hours following a cesarean section.
If you need help recovering or have other special health needs	Home health care	$20 copayment/ visit	Not Covered	Limited to 100 visits per calendar year. A periodic visit by either a Nurse or Therapist, or up to 4 hours of Home Health Care Services. Pre-certification required or 50% reduction in benefits.
	Rehabilitation services	$20 copayment/ visit	Not Covered	Therapies included: occupational, physical, speech. Limited to a maximum of 52 visits per calendar year, combined with Chiropractic and/or Acupuncture visits.
	Habilitation services	$20 copayment/ visit	Not Covered	Therapies included: occupational, physical, speech. Limited to a maximum of 52 visits per calendar year, combined with Chiropractic and/or Acupuncture visits.
	Skilled nursing care	$0 copayment	Not Covered	Limited to 100 days per calendar year.
	Durable medical equipment	$0 copayment	Not Covered	Pre-Certification required for each DME purchase over $1,500 and DME rental over $500 a month.
	Hospice services	$0 copayment	Not Covered	Pre-certification is required.
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.)

- Housekeeping services
- Cosmetic Surgery
- Long Term Care
- Supportive Environment Materials
- Dental Care (Child, Adult)
- Non-Emergency Care when traveling outside the U.S.
- Expenses for necessities of living
- Weight Loss Programs for dependents.
- Routine Eye Care
- Routine Dental Care

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

- Acupuncture
- Hearing Deficit Services
- Morbid Obesity Surgery

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 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: BRMS at 1-866-730-8588 .

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 1-866-730-8588

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-730-8588

Chinese (中文): 如果需要中文的帮助，□□□□□□□ 1-866-730-8588

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-730-8588

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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

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	$0
Specialist *[cost sharing]*	$20
Hospital (facility) *[cost sharing]*	$0
Other *[cost sharing]*	$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	$7,540

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$20
Coinsurance	$0
What isn't covered	
Limits or exclusions	$150
The total Peg would pay is	$170

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

The plan's overall deductible	$0
Specialist *[cost sharing]*	$20
Hospital (facility) *[cost sharing]*	$0
Other *[cost sharing]*	$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	$5,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$480
Coinsurance	$0
What isn't covered	
Limits or exclusions	$80
The total Joe would pay is	$560

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

The plan's overall deductible	$0
Specialist *[cost sharing]*	$20
Hospital (facility) *[cost sharing]*	$0
Other *[cost sharing]*	$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	$2,500

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$140
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$140

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

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, 1-866-730-8588. 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.vbas.com or call 1-866-730-8588 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$275 single/ $1,100 family In and out of Network Waived for Preventive Health Care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. The **deductible** starts over on January 1st. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there services covered before you meet your deductible?	Yes	See the chart starting on page 2 for costs for services this plan covers.
Are there other deductibles for specific services?	No	See the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	Maximum In-Network $1,475 coinsurance / person, $5,900 family. Maximum Out of Network $5,075 coinsurance/person, $20,300 coinsurance/family. Pharmacy Maximum $5,125/person, $7,300/family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.

What is not included in the out-of-pocket limit?	Non-covered services, cost containment penalties and copayments. Certain specialty pharmacy drugs are considered non-essential health benefits and fall outside the out-of-pocket limits. The cost of these drugs (though reimbursed by the manufacturer at no cost to you) will not be applied towards satisfying your out-of-pocket maximums.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**. Non-Essential specialty pharmacy drugs: even though you incur these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do you need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.

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	10% coinsurance	40% coinsurance	Subject to Plan deductible.
	Specialist visit	10% coinsurance	40% coinsurance	Subject to Plan deductible.
	Preventive care/screening/ immunization	$0 copayment	$0 copayment	As recommended by the United States Preventative Services Task Force. Not subject to Plan deductible.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	40% coinsurance	Subject to Plan deductible.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	40% coinsurance	Subject to Plan deductible.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.express-scripts.com	Generic drugs	$7 copayment retail/ $14 copayment mail-order	$7 copayment retail/ $14 copayment mail-order	Female Oral Contraceptives (Generic) have no copayment for retail & mail order. Covers up to a 34 day supply (retail) or 90 day supply (mail order or Smart90).
	Formulary brand drugs	$25 copayment retail/ $50 copayment mail-order	$25 copayment retail/ $50 copayment mail-order	Covers up to a 34 day supply (retail) or 90 day supply (mail order or Smart90).
	Non-Formulary brand drugs	$50 copayment retail/ $100 copayment mail-order	$50 copayment retail/ $100 copayment mail-order	Covers up to a 34 day supply (retail) or 90 day supply (mail order or Smart90).
	Specialty Drugs	Subject to the applicable copayment as Generic, Formulary or Non-Formulary.	Not Covered	Covers 34 - 90 day supply through Accredo Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	Subject to Plan deductible.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	Subject to Plan deductible.
If you need immediate medical attention	Emergency room care	10% coinsurance after $100 copayment	10% coinsurance after $100 copayment	Subject to Plan deductible. Copayment waived if admitted
	Emergency medical transportation	10% coinsurance	10% coinsurance	Subject to Plan deductible.
	Urgent care	10% coinsurance	10% coinsurance	Subject to Plan deductible

If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	Pre-Certification required, subject to Plan deductible.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	Subject to Plan deductible.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	40% coinsurance	Subject to Plan deductible.
	Inpatient services	10% coinsurance	40% coinsurance	Pre-Certification required, subject to Plan deductible.
If you are pregnant	Office visits	10% coinsurance	40% coinsurance	Subject to Plan deductible.
	Childbirth/delivery professional services	10% coinsurance	40% coinsurance	Subject to Plan deductible.
	Childbirth/delivery facility services	10% coinsurance	40% coinsurance	Pre-certification required if stay exceeds 48 hours following normal vaginal delivery or 96 hours following a cesarean section. Subject to Plan deductible.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	40% coinsurance	Subject to Plan deductible. A periodic visit by either a Nurse or Therapist, or up to 4 hours of Home Health Care Services. Pre-certification required or 50% reduction in benefits.
	Rehabilitation services	10% coinsurance	40% coinsurance	Subject to Plan deductible; Out-of-Network Physical Therapy, Acupuncture and Chiropractic Services are not covered.
	Habilitation services	10% coinsurance	40% coinsurance	Subject to Plan deductible; Out-of-Network Physical Therapy, Acupuncture and Chiropractic Services are not covered.
	Skilled nursing care	10% coinsurance	40% coinsurance	Pre-certification required, 100 days per Calendar year, subject to Plan deductible.
	Durable medical equipment	10% coinsurance	40% coinsurance	Subject to Plan deductible. Pre-Certification required for each DME purchase over $1,500 and DME rental over $500 a month.
	Hospice services	10% coinsurance	40% coinsurance	Precertification required, subject to Plan deductible.
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

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

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.)

- Housekeeping services
- Cosmetic Services
- Long Term Care
- Infertility
- Supportive Environment Materials
- Dental Care (Child, Adult)
- Non-Emergency Care when traveling outside the U.S.
- Expenses for necessities of living
- Acupuncture – Out-of-Network
- Chiropractic – Out-of-Network
- Physical Therapy – Out-of-Network
- Routine Eye Care

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

- Acupuncture – In Network
- Morbid Obesity Services
- Chiropractic Care – In Network
- Hearing Deficit Services
- Physical Therapy – In Network
- Weight Loss Programs – up to $1,000 for employees only

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 Employees 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: BRMS at 1-866-730-8588.

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 1-866-730-8588.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-730-8588.]

[Chinese (中文): 如果需要中文的帮助，□□□□□□□ 1-866-730-8588.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-730-8588.]

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	$275
Specialist *[cost sharing]*	10%
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	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	$7,540

In this example, Peg would pay:

Cost Sharing	
Deductibles	$275
Copayments	$0
Coinsurance	$700
What isn't covered	
Limits or exclusions	$150
The total Peg would pay is	$1,135

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

The plan's overall deductible	$275
Specialist *[cost sharing]*	10%
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	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	$5,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$275
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$80
The total Joe would pay is	$855

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

The plan's overall deductible	$275
Specialist *[cost sharing]*	10%
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	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	$2,500

In this example, Mia would pay:

Cost Sharing	
Deductibles	$275
Copayments	$100
Coinsurance	$225
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$600

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