



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, call 1-800-251-5014. 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/](https://www.healthcare.gov/sbc-glossary/) or call 1-800-251-5014 to request a copy.

Important Questions	Answers	Why This Matters:
<u>What is the overall deductible?</u>	\$750/individual, \$2,250/family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<u>Are there services covered before you meet your deductible?</u>	Yes. Contract and out-of-area <u>provider</u> office visits, online visit, <u>emergency room care</u> for an <u>emergency medical condition</u> , contract <u>provider</u> preventive care, adult physical exam benefit with non-contract <u>providers</u> , <u>preventive care</u> for children with an out-of-area <u>provider</u> , outpatient <u>prescription drugs</u> , dental and vision expenses.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
<u>Are there other deductibles for specific services?</u>	No.	You don't have to meet <u>deductibles</u> for specific services.
<u>What is the out-of-pocket limit for this plan?</u>	The <u>out-of-pocket limit</u> for <u>cost sharing</u> for contract <u>providers</u> (includes <u>copays</u> and <u>coinsurance</u> ) is <b>\$3,000/individual, \$6,000/family</b> . The <u>out-of-pocket limit</u> for in-network outpatient <u>prescription drugs</u> is <b>\$1,875/individual, \$3,750/family</b> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<u>What is not included in the out-of-pocket limit?</u>	Medical <u>out-of-pocket limit</u> does not include <u>premiums</u> , <u>balance-billing</u> charges, penalties for failure to obtain <u>preauthorization</u> , outpatient <u>prescription drugs</u> , dental/ vision expenses, non-contract provider <u>cost sharing</u> (except for <u>emergency room care</u> for an <u>emergency medical condition</u> ) and health care this <u>plan</u> doesn't cover. Prescription drug <u>out-of-pocket limit</u> (in-network) does not include <u>premiums</u> , <u>balance-billing</u> charges, amounts over generic equivalent cost if you choose a brand drug when a generic is available, medical expenses, dental/ vision expenses, out-of-network pharmacy expenses, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Important Questions	Answers	Why This Matters:
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> or call 1-800-251-5014 for a list of contract <u>providers</u> in California. For a list of Blue Card contract <u>providers</u> outside of California, see <a href="http://www.bluecares.com">www.bluecares.com</a> or call 1-888-810-2583. For a list of chemical dependency <u>providers</u> , call Assistance & Recovery Program (ARP) at 1-800-562-3277.	You pay the least if you use a <u>contract provider</u> . You pay more if you use an <u>out-of-area provider</u> . You will pay the most if you use a <u>non-contract provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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
		Contract Provider (You will pay the least)	Out-of-Area Provider (You will pay more)	Non-Contract 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	LiveHealth online visit: \$15 <u>copay</u> /visit, <u>deductible</u> does not apply. Office visit: \$15 <u>copay</u> /visit, <u>deductible</u> does not apply.	LiveHealth online visit: Not covered. Office visit: \$15 <u>copay</u> /visit 20% <u>coinsurance</u> , <u>deductible</u> does not apply.	LiveHealth online visit: Not covered. Office visit: 40% <u>coinsurance</u>	None.
	Specialist visit	\$15 <u>copay</u> /visit, <u>deductible</u> does not apply.	\$15 <u>copay</u> /visit plus 20% <u>coinsurance</u> . <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	Second surgical opinion not subject to a <u>copay</u> .
	Preventive care/screening/immunization	No charge, <u>deductible</u> does not apply.	Routine exam + related <u>diagnostic tests</u> : No charge up to \$150/exam, <u>deductible</u> does not apply. You are responsible for all amounts above \$150. Mammogram/immunizations: 20% <u>coinsurance</u> . Well-child care: 20% <u>coinsurance</u> , <u>deductible</u> does not apply.	Routine exam + related <u>diagnostic tests</u> : No charge up to \$150/exam, <u>deductible</u> does not apply. You are responsible for all amounts above \$150. Well-child care: 40% <u>coinsurance</u> . Mammogram/immunizations: 40% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. Non-contract <u>provider</u> services limited to physical exam + related <u>diagnostic tests</u> , immunizations, mammography, and well-child care (subject to age and frequency limitations).
If you have a test	Diagnostic test (x-ray, blood work)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Out-of-Area Provider (You will pay more)	Non-Contract Provider (You will pay the most)	
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preadmission</u> required from American Imaging Management.
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at <a href="http://www.optumrx.com">www.optumrx.com</a> or call 1-855-672-3644.</p>	Generic drugs	Retail (34-day supply): \$5 <u>copay/fill</u> . Mail Order (90-day supply): \$10 <u>copay/fill</u>	You pay 100% up front and submit a claim for reimbursement. The <u>plan</u> will reimburse no more than it would have paid had you used a <u>network</u> retail pharmacy.		<ul style="list-style-type: none"> <li>• <u>Deductible</u> does not apply.</li> <li>• If the drug cost is less than the <u>cost sharing</u>, you pay just the drug cost.</li> <li>• 90-day supply available at retail for 3x the otherwise applicable retail <u>copay</u>.</li> <li>• If you choose a brand name drug when a generic is available and medically appropriate, the <u>plan</u> will pay only up to the reasonable cost of the generic equivalent. Any amounts above the cost of the generic equivalent do not count toward your <u>prescription drug out-of-pocket limit</u>.</li> </ul>
	Formulary (Preferred) brand drugs	Retail (34-day supply): 10% <u>coinsurance</u> (maximum \$100 <u>copay/fill</u> ). Mail Order (90-day supply): 5% <u>coinsurance</u> (maximum \$100 <u>copay/fill</u> )			
	Non-Formulary (Non-preferred) brand drugs	Retail (34-day supply): 25% <u>coinsurance</u> (maximum \$200 <u>copay/fill</u> ). Mail Order (90-day supply): 15% <u>coinsurance</u> (maximum \$200 <u>copay/fill</u> )			
	Specialty drugs	20% <u>coinsurance</u> up to the following <u>maximum copays/fill</u> : <ul style="list-style-type: none"> <li>• Generic: \$50</li> <li>• Formulary: \$100</li> <li>• Non-Formulary: \$200</li> </ul>	Not covered	Not covered	<ul style="list-style-type: none"> <li>• <u>Deductible</u> does not apply.</li> <li>• Chemotherapy drugs may be covered at an out-of-network pharmacy.</li> <li>• Some drugs are subject to step therapy or require <u>preauthorization</u>. Contact Optum for more information.</li> </ul>

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Out-of-Area Provider (You will pay more)	Non-Contract Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Your <u>cost sharing</u> for services of a non-contract anesthesiologist, assistant surgeon or radiologist will be at the contract level if received in a contract facility and ordered by a contract physician.
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u> <u>Deductible</u> does not apply.	20% <u>coinsurance</u> <u>Deductible</u> does not apply.	20% <u>coinsurance</u> <u>Deductible</u> does not apply.	Professional/physician charges may be billed separately. See row titled "If you visit a health care <u>provider's</u> office or clinic" row above.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	<u>Urgent care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Private room covered up to cost of semi-private room, unless <u>medically necessary</u> . <u>Preadmission</u> required for elective admission.
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Your <u>cost sharing</u> for services of a non-contract anesthesiologist, assistant surgeon or radiologist will be at the contract level if received in a contract facility and ordered by a contract physician.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Out-of-Area Provider (You will pay more)	Non-Contract Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	LiveHealth online visit: \$15 <u>copay</u> /visit, <u>deductible</u> does not apply. Office visit: \$15 <u>copay</u> /visit, <u>deductible</u> does not apply. Other outpatient services: 20% <u>coinsurance</u>	LiveHealth online visit: Not covered. Office visit: \$15 <u>copay</u> / visit plus 20% <u>coinsurance</u> , <u>deductible</u> does not apply. Other outpatient services: 20% <u>coinsurance</u>	LiveHealth online visit: Not covered. Office visit: 40% <u>coinsurance</u> . Other outpatient services: 40% <u>coinsurance</u>	Referral and <u>preauthorization</u> by ARP is recommended so that you can be directed to a Contract Provider.
	Inpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Private room covered up to cost of semi-private room, unless <u>medically necessary</u> . <u>Preauthorization</u> from Anthem required for elective mental health admission, from ARP for elective chemical dependency admission.
If you are pregnant	Office visits	No charge, <u>deductible</u> does not apply.	\$15 <u>copay</u> /visit plus 20% <u>coinsurance</u> , <u>deductible</u> does not apply.	40% <u>coinsurance</u>	<ul style="list-style-type: none"> <li>Depending on the type of services, a <u>copay</u>, <u>coinsurance</u>, or <u>deductible</u> may apply.</li> <li>Maternity care may include tests and services described somewhere else in the SBC (see row titled "If you have a test" for coverage of an ultrasound).</li> </ul>
	Childbirth/delivery professional services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Delivery expenses are not covered for dependent children.
	Childbirth/delivery facility services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Private room covered up to cost of semi-private room, unless <u>medically necessary</u> . <u>Preauthorization</u> required for hospital stay longer than 48 hours for vaginal delivery or 96 hours for cesarean section. Delivery expenses are not covered for dependent children.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Out-of-Area Provider (You will pay more)	Non-Contract Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 1 visit/day, per provider, 60 visits/year. Maximums do not apply to the treatment of MH/SUD conditions.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required for elective inpatient admission. Limited to 40 visits/year for physical therapy and chiropractic care combined. <u>Medically necessary</u> speech therapy is covered. Maximums do not apply to the treatment of MH/SUD conditions. Includes treatment for autism.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Only delay in childhood speech is covered. Limited to 20 visits/year, 40 visits/lifetime. Maximums do not apply to the treatment of MH/SUD conditions. Includes treatment for autism.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Private room covered up to cost of semi-private room, unless <u>medically necessary</u> . <u>Preauthorization</u> required for elective admission. Limited to 180 days/year. Maximums do not apply to the treatment of MH/SUD conditions.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> recommended for any equipment costing more than \$500. Rental charges covered up to reasonable purchase price.
	<u>Hospice services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 1 visit/day, per <u>provider</u> , 60 days/year.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	If your employer elects to include the optional vision <u>plan</u> , it will be through a separate policy.
	Children's glasses	Not covered	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Not covered	If your employer elects to include the optional dental <u>plan</u> , it will be through a separate policy.

## 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"><li>• Cosmetic surgery</li><li>• Dental care (Adult &amp; Child) (may be available through separate dental <u>plan</u>)</li></ul>	<ul style="list-style-type: none"><li>• Infertility treatment</li><li>• Long-term care</li><li>• Private duty nursing</li></ul>	<ul style="list-style-type: none"><li>• Routine eye care (Adult &amp; Child) (may be available through separate vision <u>plan</u>)</li><li>• Weight loss programs (except as required by the health reform law)</li></ul>
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### 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"><li>• Acupuncture (limited to 1 visit/week and 12 visits/diagnosis unless <u>preauthorization</u> is obtained)</li></ul>	<ul style="list-style-type: none"><li>• Bariatric surgery (only in a Center of Medical Excellence or Blue Distinction Center. <u>Preauthorization</u> required)</li><li>• Chiropractic care (up to 40 visits/year combined with physical therapy)</li></ul>	<ul style="list-style-type: none"><li>• Hearing aids (limited to \$1,350/ear every 4 years)</li><li>• Non-emergency care when traveling outside the U.S.</li><li>• Routine foot care</li></ul>
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**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](http://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](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: the Fund Office at 1-800-251-5014. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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 1-800-251-5014.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-251-5014.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-251-5014.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-800-251-5014.

*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 <u>deductible</u>	\$750
■ <u>Specialist copayment</u>	\$15
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other 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*)

**Total Example Cost** **\$12,700**

In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$750
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$2,080
What isn't covered	
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 plan's overall <u>deductible</u>	\$750
■ <u>Specialist copayment</u>	\$15
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other 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*)

**Total Example Cost** **\$5,600**

In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$120
<u>Copayments</u>	\$240
<u>Coinsurance</u>	\$390
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$750</b>

### Mia's Simple Fracture

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

■ The plan's overall <u>deductible</u>	\$750
■ <u>Specialist copayment</u>	\$15
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other 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*)

**Total Example Cost** **\$2,800**

In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$750
<u>Copayments</u>	\$70
<u>Coinsurance</u>	\$330
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,150</b>

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