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 1-800-844-8392. 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.dol.gov/ebsa/healthreform or call 1-800-844-8392 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not applicable.	This plan does not have a deductible.
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?	The medical coinsurance maximum for contract providers is **$3,000**/individual, **$6,000**/family. The out-of-pocket limit for cost sharing for contract providers (includes copays and coinsurance) is **$5,275**/individual; **$10,550**/family. The out-of-pocket limit for in-network outpatient prescription drugs is **$1,875**/individual, **$3,750**/family.	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?	Medical out-of-pocket limit does not include: premiums, balance-billing charges, penalties for failure to obtain preauthorization, outpatient prescription drug expenses, dental and vision expenses, non-contract provider cost sharing (except for emergency room care for an emergency medical condition) and health care this plan doesn't cover. Prescription drug out-of-pocket limit (in-network) does not include: premiums, balance-billing charges, amounts over the generic equivalent cost if you choose a brand drug when a generic is available, medical expenses, dental and vision expenses, out-of-network pharmacy expenses, 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 1-800-844-8392 for a list of contract providers in California. For a list of Blue Card contract providers outside of California, see www.bluecares.com or call 1-800-810-2583. For a list of chemical dependency providers, call Assistance & Recovery Program (ARP) at 1-800-562-3277.	You pay the least if you use a contract provider. You pay more if you use an out-of-area provider. You will pay the most if you use a non-contract 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.

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	$15 copay/visit.	$15 copay/visit plus 20% coinsurance.	$15 copay/visit plus 40% coinsurance	None.
	Specialist visit	$15 copay/visit.	$15 copay/visit plus 20% coinsurance.	$15 copay/visit plus 40% coinsurance	Second surgical opinion not subject to a copay.
If you visit a health care provider's office or clinic	Preventive care/screening/ immunization	No charge	Routine physical exam + related diagnostic tests: No charge up to $150/exam. You are responsible for all amounts above $150. Mammogram and immunizations: 20% coinsurance. Well-child care: 20% coinsurance.	Routine physical exam + related diagnostic tests: No charge up to $150/exam. You are responsible for all amounts above $150. Well-child care: 40% coinsurance. Mammogram and immunizations: 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. Non-contract provider services limited to physical exam + related diagnostic tests, immunizations, mammography, and well-child care (subject to age and frequency limitations).

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 a test	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance	40% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	40% coinsurance	Preauthorization required from American Imaging Management.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com or call 1-855-672-3644.	Generic drugs	Retail (34-day supply): $5 copay/fill Mail Order (90-day supply): $10 copay/fill	You pay 100% up front and submit a claim for reimbursement. The plan will reimburse no more than it would have paid had you used a network retail pharmacy.	You pay 100% up front and submit a claim for reimbursement. The plan will reimburse no more than it would have paid had you used a network retail pharmacy.	• If the drug cost is less than the cost sharing, you pay just the drug cost. • 90-day supply available at retail for three times the otherwise applicable retail copay. • If you choose a brand name drug when a generic is available and medically appropriate, the plan 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 prescription drug out-of-pocket limit. • Some drugs are subject to step therapy or require preauthorization. • No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate).
	Formulary (Preferred) brand drugs	Retail (34-day supply): 10% coinsurance (maximum $100 copay/fill) Mail Order (90-day supply): 5% coinsurance (maximum $100 copay/fill)			
	Non-Formulary (Non-preferred) brand drugs	Retail (34-day supply): 25% coinsurance (maximum $200 copay/fill) Mail Order (90-day supply): 15% coinsurance (maximum $200 copay/fill)			
	Specialty drugs	20% coinsurance up to the following maximum copays/fill: • Generic: $50 • Formulary: $100 • Non-Formulary: $200	Not covered	Not covered	• Chemotherapy drugs may be covered at an out-of-network pharmacy. • Some drugs are subject to step therapy or require preauthorization. Contact Optum for more information.

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% coinsurance	20% coinsurance	20% coinsurance	None.
	Physician/ surgeon fees	20% coinsurance	20% coinsurance	40% coinsurance	Your cost sharing 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	Emergency room care	20% coinsurance	20% coinsurance	20% coinsurance	Professional/physician charges may be billed separately.
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	
	Urgent care	20% coinsurance	20% coinsurance	20% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	40% coinsurance	Private room covered up to cost of semi-private room, unless medically necessary. Preauthorization required for elective admission.
	Physician/ surgeon fees	Physician: $15 copay/visit. Surgeon, anesthesiologist: 20% coinsurance	Physician: $15 copay/visit plus 20% coinsurance. Surgeon, anesthesiologist: 20% coinsurance	Physician: $15 copay/visit plus 40% coinsurance. Surgeon, anesthesiologist: 40% coinsurance	Your cost sharing 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	Office visit: $15 copay/visit. Other outpatient services: 20% coinsurance	Office visit: $15 copay/ visit plus 20% coinsurance. Other outpatient services: 20% coinsurance	Office visit: 40% coinsurance Other outpatient services: 40% coinsurance	None.
	Inpatient services	Physician: 20% coinsurance; Facility and other providers: 20% coinsurance	Physician: 20% coinsurance Facility and other providers: 20% coinsurance	Physician: 40% coinsurance, Facility and other providers: 40% coinsurance	Private room covered up to cost of semi-private room, unless medically necessary. Preauthorization from Anthem required for elective mental health admission, from ARP for elective chemical dependency admission.
If you are pregnant	Office visits	No charge	$15 copay/visit plus 20% coinsurance.	$15 copay/visit plus 40% coinsurance	• Depending on the type of services, a copay or coinsurance may apply. • 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).
	Childbirth/delivery professional services	Physician: $15 copay/visit, Surgeon, anesthesiologist: 20% coinsurance	Physician: $15 copay/visit plus 20% coinsurance. Surgeon, anesthesiologist: 20% coinsurance	Physician: $15 copay/visit plus 40% coinsurance. Surgeon, anesthesiologist: 40% coinsurance	Delivery expenses are not covered for dependent children.
	Childbirth/ delivery facility services	20% coinsurance	20% coinsurance	40% coinsurance	Private room covered up to cost of semi-private room, unless medically necessary. Preauthorization 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	Home health care	20% coinsurance	20% coinsurance	20% coinsurance	Limited to 1 visit/day, 60 visits/year.
	Rehabilitation services	20% coinsurance	20% coinsurance	40% coinsurance	Preauthorization required for elective inpatient admission. Limited to 40 visits/year for physical therapy and chiropractic care combined. Medically necessary speech therapy is covered.
	Habilitation services	20% coinsurance	20% coinsurance	40% coinsurance	Only delay in childhood speech is covered. Limited to 20 visits/year, 40 visits/lifetime.
	Skilled nursing care	20% coinsurance	20% coinsurance	10% coinsurance	Private room covered up to cost of semi-private room, unless medically necessary. Preauthorization required for elective admission. Limited to 180 days/year. Admission must begin within 14 days of inpatient hospital stay.
	Durable medical equipment	20% coinsurance	20% coinsurance	20% coinsurance	Preauthorization recommended for any equipment costing more than $500. Rental charges covered up to reasonable purchase price.
	Hospice services	20% coinsurance	20% coinsurance	40% coinsurance	Limited to 1 visit/day, per provider, 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 plan, it will be through a separate VSP 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 plan, it will be through a separate Delta Dental 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.)		
• Cosmetic surgery • Dental care (Adult & Child) (may be available through separate dental plan)	• Infertility treatment • Long-term care • Private duty nursing	• Routine eye care (Adult & Child) (may be available through separate vision plan) • Weight loss programs (except as required by the health reform law)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (limited to 1 visit/week and 12 visits/diagnosis unless preauthorization is obtained) • Bariatric surgery (only in a Center of Medical Excellence or Blue Distinction Center. Preauthorization required)	• Chiropractic care (up to 40 visits/year combined with physical therapy) • Hearing aids (limited to $450/ear every 3 years)	• Non-emergency care when traveling outside the U.S. • Routine foot care

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 Fund Office at 1-800-444-8392. 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.

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 1-800-444-8392.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa1-800-444-8392.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-444-8392.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-444-8392.

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** **$0**
- **Specialist copayment** **$15**
- **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:

Cost Sharing	
Deductibles	$0
Copayments	$70
Coinsurance	$2,280
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$2,360**

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 copayment** **$15**
- **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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$290
Coinsurance	$560
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$8809**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$15**
- **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:

Cost Sharing	
Deductibles	$0
Copayments	$60
Coinsurance	$320
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$380**

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