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 Trust Fund Office at 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.dol.gov/ebsa/healthreform.com or call 1-800-251-5014 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$250/individual, $750/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Contract Provider (and certain Non-Contract Provider) preventive care, hearing aid benefit, outpatient prescription drugs (some subject to separate deductible outlined below), chemical dependency, dental, and vision are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	Yes. $100/individual for retail brand name prescription drugs (except for brand name PPI drugs). There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Medical Limit: Contract Providers: $2,500/individual, $5,000/family; Non-Contract Providers: $5,000/individual, $15,000/family. Overall ACA Limit (in-network only, applicable only to Reduced Comprehensive Medical Benefit): $6,300/individual, $13,600/family. Prescription drugs (in-network): $1,600/individual, $2,200/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, dental & vision plan expenses, prescription drugs, penalties for failure to obtain preauthorization, amounts over the reference-based price for certain surgeries, certain treatment at a Non-Center of Medical Excellence facility, health care this plan doesn't cover and Non-Contract copayments and coinsurance. Prescription Drug: Out-of-Pocket Limit does not include Medical expenses, premiums, balance-billing charges, dental and vision plan expenses, penalties for failure to obtain preauthorization, amounts over the max for PPI drugs, health care this plan doesn't cover, and Non-Participating Pharmacy expenses.	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 for a list of Contract Providers in California or call the Trust Fund Office. For a list of Contract Providers outside of California, see www.bluecares.com or call 1-800-810-2583. For Contract chemical dependency providers, call Assistance Recovery Program (ARP) at (800) 562-3277. For hearing aids, call (888) 432-7464 or (800) 442-8231.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network 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.

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	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	10% coinsurance	10% coinsurance plus balance billing	20% coinsurance plus balance billing	None
	Specialist visit	10% coinsurance	10% coinsurance plus balance billing	20% coinsurance plus balance billing	None
	Preventive care/screening/ Immunization	No charge. Deductible does not apply.	Mammogram, Pap smear, colorectal cancer screening, adult immunizations: 10% coinsurance plus balance billing. Deductible does not apply. All other preventive services: Not covered.	Mammogram, Pap smear, colorectal cancer screening, adult immunizations: 20% coinsurance plus balance billing. Deductible does not apply. All other preventive services: Not covered.	• No charge for physical exam (employee and spouse, once per person per calendar year) and well-child care (except balance billing for out-of-area and Non-Contract providers.) Deductible does not apply. • 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. • Well-child care with an Out-of-Area or Non-Contract Provider does not count toward the Non-Contract Provider out-of-pocket limit.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	10% coinsurance plus balance billing	20% coinsurance plus balance billing	Professional/physician charges may be billed separately.

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	Non-Contract Provider (You will pay the most)	
	Imaging (CT/PET scans, MRIs)	10% coinsurance	10% coinsurance plus balance billing	20% coinsurance plus balance billing	Preauthorization by American Imaging Management is required to avoid non-payment. Professional/physician charges may be billed separately
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	Generic drugs	Retail Pharmacy (34-day supply): $5 copayment/script. Mail Order (90-day supply): $10 copayment/script.	You pay the full cost at the time of purchase, and submit a claim for reimbursement. You will be reimbursed the allowed amount less the applicable participating pharmacy copayments. You are responsible for any amount the pharmacy charges above the contract amount the participating pharmacy would have charged.		• A 90-day supply available at contract retail pharmacy for three copayments/script. • Retail brand name drugs (except for PPI drugs used for acid reflux) are subject to a separate $100 deductible. Medical plan deductible does not apply to prescription drugs. • PPI drugs maximum Plan payment of $30/script for retail, $90/script for mail order. Charges over plan limits do not count toward the prescription drug out-of-pocket limit. • If you obtain a brand drug at a Retail Pharmacy when a generic drug is available, you pay the brand copayment + the cost difference between the brand and generic drug (unless Provider specifies no generic substitution). • If the cost of the drug is less than the copayment, you pay just the drug cost. • Some drugs are subject to step therapy, quantity limits and preauthorization. • No charge for ACA-required generic preventive drugs (such as FDA-approved generic contraceptives) or brand name contraceptives if a generic is medically inappropriate.
	Preferred brand drugs	Retail Pharmacy (34-day supply): $25 copayment/script. Mail Order (90-day supply): $50 copayment/script.			
	Non-preferred brand drugs	Retail Pharmacy (34-day supply): $40 copayment/script. Mail Order (90-day supply): $80 copayment/script.			
	Specialty drugs	20% coinsurance up to the copayment max (Generic: $50/script, Preferred brand: $100/ script, Non-Preferred $200/script)	Not covered		Available only through OptumRx Specialty Drug Program at (866) 218-5445.

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	Non-Contract Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	10% coinsurance plus balance billing	10% coinsurance plus balance billing	• Outpatient surgery requires preauthorization to avoid a $300 penalty. • Max of $6,000 is payable for an arthroscopy, $2,000 for cataract surgery, $1,500 for colonoscopy (facility fee) if you have your surgery at an outpatient hospital rather than an ambulatory surgical center; max of $34,000 for facility charges for a single hip or knee joint replacement surgery. Charges over plan limits do not count toward the out-of-pocket limit. • Per-surgery max of $500 for services at a Non-Contract Ambulatory Surgery Facility. • Charges over plan limits do not count toward the out-of-pocket limit.
	Physician/surgeon fees	10% coinsurance	10% coinsurance plus balance billing	20% coinsurance plus balance billing	None.
If you need immediate medical attention	Emergency room care	$100 copayment/visit, then 10% coinsurance	$100 copayment/visit, then 10% coinsurance plus balance billing	$100 copayment/visit, then 10% coinsurance plus balance billing	Copayment waived if you are admitted directly to the hospital. Professional/physician charges may be billed separately
	Emergency medical transportation	10% coinsurance	10% coinsurance plus balance billing	10% coinsurance (20% coinsurance if not an emergency medical condition) plus balance billing	Professional/physician charges may be billed separately
	Urgent care	10% coinsurance	10% coinsurance plus balance billing	10% coinsurance plus balance billing	Professional/physician charges may be billed separately

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	Non-Contract Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	10% coinsurance plus balance billing	10% coinsurance plus balance billing	• Preauthorization is required to avoid a $300 penalty. • A $34,000 maximum for facility charges for a single hip or knee joint replacement surgery. Charges over plan limits do not count toward the out-of-pocket limit. • No benefits for transplants or bariatric surgery performed at a facility that is not an Anthem Center of Medical Excellence (CME) or a Blue Distinction Center. Your expenses at a facility that is not a CME or Blue Distinction Center do not count toward the out-of-pocket limit. • It is encouraged that an Anthem Blue Cross CME or Blue Distinction Center be considered for cardiac care, spinal surgery and treatment for complex and rare cancers. • Coverage provided for semi-private room, intensive care unit, or cardiac care unit.
	Physician/surgeon fees	10% coinsurance	10% coinsurance plus balance billing	20% coinsurance plus balance billing	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits and other outpatient: 10% coinsurance	Office visits and other outpatient: 10% coinsurance plus balance billing	Office visits and other outpatient: 10% coinsurance plus balance billing	• Chemical dependency services are not covered for dependent children. • Deductible does not apply to covered substance abuse treatment.
	Inpatient services	10% coinsurance	10% coinsurance plus balance billing	10% coinsurance plus balance billing	• Preauthorization is required to avoid a $300 penalty. • Chemical dependency services are not covered for dependent children. • Deductible does not apply to covered substance abuse treatment.

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	Non-Contract Provider (You will pay the most)	
If you are pregnant	Office visits	No charge. Deductible does not apply.	10% coinsurance plus balance billing	20% coinsurance plus balance billing	• Cost sharing does not apply for preventive services. • Depending on the type of services, coinsurance may apply. • Maternity care may include tests and services described somewhere else in the SBC (see row "If you have a test" for coverage of an ultrasound).
	Childbirth/delivery professional services	10% coinsurance	10% coinsurance plus balance billing	20% coinsurance plus balance billing	• Preauthorization by Anthem is required only if hospital stay is longer than 48 hours for vaginal delivery or 96 hours for C-section. • Delivery expenses are not covered for dependent children.
	Childbirth/delivery facility services	10% coinsurance	10% coinsurance plus balance billing	10% coinsurance plus balance billing	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	10% coinsurance plus balance billing	20% coinsurance plus balance billing	None.
	Rehabilitation services	10% coinsurance	10% coinsurance plus balance billing	20% coinsurance plus balance billing	Outpatient physical & occupational therapy max is 20 visits/year (40 visits if 24 months before/after related surgery or stroke).
	Habilitation services	Not covered	Not covered	Not covered	You must pay 100% of these services, even from a Contract provider.
	Skilled nursing care	10% coinsurance	10% coinsurance plus balance billing	20% coinsurance plus balance billing	Preauthorization is required to avoid non-payment. Coverage provided for semi-private room.
	Durable medical equipment	10% coinsurance	10% coinsurance plus balance billing	20% coinsurance plus balance billing	Preauthorization is recommended for equipment costing more than $500 before renting or buying.
	Hospice services	10% coinsurance	10% coinsurance plus balance billing	20% coinsurance plus balance billing	Covered if terminally ill.
If your child needs dental or eye care	Children's eye exam	$7.50 copayment/visit	$7.50 copayment/visit plus amounts over $45		Your vision coverage is available under a separate vision plan. Cost sharing for vision services does not count toward the medical plan's out-of-pocket limit. Medical plan deductible does not apply.
	Children's glasses	No charge	Amounts over $34		
	Children's dental check-up	No charge	No charge except balance billing		Your dental coverage is available under a separate dental plan. Your cost sharing for dental services does not count toward the medical plan's out-of-pocket limit. Medical plan deductible does not apply.

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	• Long-term care	• Routine foot care
• Habilitation services	• Private-duty nursing	• Weight loss programs (except as required under health reform)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (16 visits/treatment series)	• Dental care (Adult) (available only through a separate benefit administered by Delta Dental, up to $2,500/calendar year)	• Infertility treatment (only services to diagnose)
• Bariatric Surgery (if preauthorization is received and surgery is performed at a Center of Medical Excellence)	• Hearing aids ($1,350/ear every 4 years)	• Non-emergency care when traveling outside the U.S.
• Chiropractic care (up to 20 visits/year)		• Routine eye care (Adult) (available only through separate benefit administered by VSP)

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 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 Zenith 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.

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, kwiijigo 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 deductible** **$250**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$260
Copayments	$0
Coinsurance	$1,090
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$1,370**

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** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$350
Copayments	$810
Coinsurance	$90
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,250**

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

- **The plan's overall deductible** **$250**
- **Specialist coinsurance** **10%**
- **Hospital ER (facility)** **$100 copayment + 10% coinsurance**
- **Other coinsurance** **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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$260
Copayments	$100
Coinsurance	$240
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.