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, visit www.local39benefits.org or call 1-800-622-0547. 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 1-800-622-0547 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$170**/individual, **$340**/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. Hospital facility charges (including outpatient hospital charges on the day of surgery), outpatient facility charges for emergency surgery, emergency treatment of a non-occupational injury on the date of the accident or the following day, Skilled Nursing Facility, and outpatient preoperative testing within 7 days of scheduled covered surgery 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.
Are there other deductibles for specific services?	Yes. Active Employees (but not Retirees) are eligible for dental benefits. Depending on the dental option you choose, you may have a deductible on dental services under a separate plan. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before the dental plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$1,000**/individual in a two-calendar-year period.	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, deductibles, copayments, charges in excess of annual maximum benefits, penalties for failure to obtain preauthorization, outpatient prescription drug costs, dental and vision 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, www.bluecares.com, or call 1-800-810-BLUE for a list of network providers.	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
		In-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	30% coinsurance	None
	Specialist visit	10% coinsurance	30% coinsurance	
	Preventive care/screening/ Immunization	10% coinsurance	30% coinsurance	• Physical exam for those three years and older limited to a maximum of $280 per exam. • Mammogram, pelvic exam, pap test, colon cancer screening and prostate screening are covered. Age and frequency guidelines may apply. *See pages 41-42 of your SPD. • Virtual colonoscopy is not covered. • 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.

*For more information about limitations and exceptions, see plan or policy document at www.local39benefits.org or call 1-800-622-0547.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	Preoperative outpatient testing within seven days of a scheduled covered surgery is covered at no charge, deductible does not apply. Professional/physician charges may be billed separately.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	Generic drugs	$4 copayment/fill	You pay 100% at the time of purchase and file a claim for reimbursement with OptumRx for reimbursement of the cost of the drug less the $4 copayment/fill.	• Retail pharmacy fill limited to 34-day supply or 100 tablets (whichever is greater). Mail Order pharmacy fill limited to 90-day supply. • If a generic is available, you pay the brand drug copayment plus the cost difference between the generic and brand drug (unless the physician indicates "dispense as written").
	Brand drugs	$7 copayment/fill	You pay 100% at the time of purchase and file a claim for reimbursement with OptumRx for reimbursement of the cost of the drug less the $7 copayment/fill.	
	Specialty drugs	Same as above.	Same as above.	Available only through OptumRx Specialty Drug Program at (855) 295-9140.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Elective surgery: 20% coinsurance Non-elective surgery: No charge.	Elective surgery: 20% coinsurance Non-elective surgery: No charge except balance billing.	Deductible does not apply for dislocated or broken bone being set, for emergency surgery, or for emergency treatment of a non-occupational injury on the day of the accident or the following day.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	20% coinsurance.	20% coinsurance	Deductible does not apply for emergency treatment of a non-occupational injury on the day of the accident or the following day. Professional/physician charges may be billed separately.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Covered from the place of the emergency medical problem to the closest hospital able to treat the problem only.
	Urgent care	10% coinsurance	30% coinsurance	Professional/physician charges may be billed separately.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge. Deductible does not apply.	20% coinsurance. Deductible does not apply.	Preauthorization required to avoid a $250 penalty. Private room covered up to cost for semiprivate room.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	Dependents are not eligible for substance abuse services.
	Inpatient services	No charge. Deductible does not apply.	20% coinsurance. Deductible does not apply.	• Preauthorization required to avoid a $250 penalty. • Private room covered up to cost for semiprivate room. • Dependents are not eligible for substance abuse services

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	• Routine nursery charges for a newborn of a dependent child are covered only in-network (and only during the dependent child mother's hospital stay). • Preauthorization required to avoid a $250 penalty if hospital stay is more than 48 hours for vaginal delivery or 96 hours for C-section. • Private room covered up to cost for semiprivate room.
	Childbirth/delivery facility services	No charge. Deductible does not apply.	20% coinsurance. Deductible does not apply.	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Limited to 100 visits per calendar year. Preauthorization required to avoid nonpayment.
	Rehabilitation services	10% coinsurance	30% coinsurance	Occupational therapy limited to $40,000 per person per injury or illness. Speech therapy covered only after a stroke, accident, injury or surgery. Private room covered up to cost for semiprivate room.
	Habilitation services	Not covered	Not covered	You pay 100% of this service, even in-network.
	Skilled nursing care	20% coinsurance. Deductible does not apply.	20% coinsurance. Deductible does not apply.	Limited to 120 days per period of disability. Preauthorization required to avoid nonpayment. Private room covered up to cost for semiprivate room.
	Durable medical equipment	10% coinsurance	30% coinsurance	Rental covered up to the purchase price.
	Hospice services	20% coinsurance	20% coinsurance	Covered if terminally ill. Bereavement counseling for immediate family members in the six-month period following a covered family member's death will be payable the same as any other outpatient counseling.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	If you elect vision coverage, it will be provided under a separate plan through Eyemed (Active Employees only).
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	If you elect dental coverage, it will be provided under a separate plan through Delta Dental or MetLife (Active Employees only).

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 (Child and Adult) (Active Employees only may elect separate dental plan)
- Hearing aids
- Habilitation services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Child and Adult) (Active Employees only may elect separate vision plan)
- Weight loss programs

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

- Acupuncture (limited to 30 visits per year, physician referral required)
- Bariatric surgery (preauthorization required to avoid a $250 penalty)
- Chiropractic care (limited to 30 visits per year and supplies are not covered)
- Infertility treatment (services to diagnose are covered)
- 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 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 Administrative Office at 1-800-622-0547 or visit www.local39benefits.org. 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 1-800-622-0547.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-622-0547.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-622-0547.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-622-0547.

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** **$170**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **0%**
- **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	$170
Copayments	$10
Coinsurance	$540
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$780**

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

- **The plan's overall deductible** **$170**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **0%**
- **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	$170
Copayments	$340
Coinsurance	$110
What isn't covered	
Limits or exclusions	$180
The total Joe would pay is	**$800**

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

- **The plan's overall deductible** **$170**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **20%**
- **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	$170
Copayments	$0
Coinsurance	$440
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$610**

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