




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 1-800-662-0547. 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:
<p>What is the overall <u>deductible</u>?</p>	<p>\$170/individual, \$340/family</p>	<p>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>.</p>
<p>Are there services covered before you meet your <u>deductible</u>?</p>	<p>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 <u>deductible</u>.</p>	<p>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.</p>
<p>Are there other <u>deductibles</u> for specific services?</p>	<p>Yes. Active Employees (but not Retirees) are eligible for dental benefits. Depending on the dental option you choose, you may have a <u>deductible</u> on dental services under a separate <u>plan</u>. There are no other specific <u>deductibles</u>.</p>	<p>You must pay all of the costs for these services up to the specific <u>deductible</u> amount before the dental <u>plan</u> begins to pay for these services.</p>
<p>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</p>	<p>\$1,000/individual in a two-calendar-year period.</p>	<p>The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.</p>
<p>What is not included in the <u>out-of-pocket limit</u>?</p>	<p><u>Premiums</u>, <u>balance-billing</u> charges, <u>deductibles</u>, <u>copayments</u>, charges in excess of annual maximum benefits, penalties for failure to obtain <u>preauthorization</u>, outpatient <u>prescription drug</u> costs, dental and vision expenses, and health care this <u>plan</u> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.anthem.com/ca , www.bluecares.com , or call 1-800-810-BLUE for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network 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.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<ul style="list-style-type: none"> Physical exam for those three years and older limited to a maximum of \$280 per exam. Mammogram, pelvic exam, pap test, colon cancer <u>screening</u> and prostate <u>screening</u> 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.
	<u>Specialist</u> visit	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
	<u>Preventive care/screening/Immunization</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	

*For more information about limitations and exceptions, see plan or policy document at www.local39benefits.org or call 1-800-662-0547.

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	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Preoperative outpatient testing within seven days of a scheduled covered surgery is covered at no charge, <u>deductible</u> does not apply. Professional/physician charges may be billed separately.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at (833) 839-7115 or www.caremark.com	Generic drugs	\$4 <u>copayment</u> /fill	You pay 100% at the time of purchase and file a claim for reimbursement with CVS Caremark for reimbursement of the cost of the drug less the \$4 <u>copayment</u> /fill.	<ul style="list-style-type: none"> • 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 <u>copayment</u> plus the cost difference between the generic and brand drug (unless the physician indicates “dispense as written”).
	Brand drugs	\$7 <u>copayment</u> /fill	You pay 100% at the time of purchase and file a claim for reimbursement with CVS Caremark for reimbursement of the cost of the drug less the \$7 <u>copayment</u> /fill.	
	<u>Specialty drugs</u>	Same as above.	Same as above.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Elective surgery: 20% <u>coinsurance</u> Non-elective surgery: No charge.	Elective surgery: 20% <u>coinsurance</u> Non-elective surgery: No charge except <u>balance billing</u> .	<u>Deductible</u> 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% <u>coinsurance</u>	30% <u>coinsurance</u>	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	<u>Emergency room care</u>	20% <u>coinsurance</u> .	20% <u>coinsurance</u>	<u>Deductible</u> 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.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Covered from the place of the emergency medical problem to the closest hospital able to treat the problem only.
	<u>Urgent care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Professional/physician charges may be billed separately.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge. <u>Deductible</u> does not apply.	20% <u>coinsurance</u> . <u>Deductible</u> does not apply.	<u>Preauthorization</u> required to avoid a \$250 penalty. Private room covered up to cost for semiprivate room.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<ul style="list-style-type: none"> Dependents are not eligible for substance abuse services.
	Inpatient services	No charge. <u>Deductible</u> does not apply.	20% <u>coinsurance</u> . <u>Deductible</u> does not apply.	<ul style="list-style-type: none"> <u>Preauthorization</u> required to avoid a \$250 penalty. Private room covered up to cost for semiprivate room. Dependents are not eligible for substance abuse services
If you are pregnant	Office visits	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<ul style="list-style-type: none"> 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).
	Childbirth/delivery facility services	No charge. <u>Deductible</u> does not apply.	20% <u>coinsurance</u> . <u>Deductible</u> does not apply.	

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)	
				<ul style="list-style-type: none"> • <u>Preauthorization</u> 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.
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Limited to 100 visits per calendar year. <u>Preauthorization</u> required to avoid nonpayment.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	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.
	<u>Habilitation services</u>	Not covered	Not covered	You pay 100% of this service, even in-network.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u> . <u>Deductible</u> does not apply.	20% <u>coinsurance</u> . <u>Deductible</u> does not apply.	Limited to 120 days per period of disability. <u>Preauthorization</u> required to avoid nonpayment. Private room covered up to cost for semiprivate room.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Rental covered up to the purchase price.
	<u>Hospice services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	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 <u>plan</u> (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 <u>plan</u> (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.)			
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Child and Adult) (Active Employees only may elect separate dental <u>plan</u>) 	<ul style="list-style-type: none"> • Hearing aids • <u>Habilitation services</u> • Long-term care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Private-duty nursing • Routine eye care (Child and Adult) (Active Employees only may elect separate vision <u>plan</u>) • Weight loss programs 	
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"> • Acupuncture (limited to 30 visits per year, physician <u>referral</u> required) 	<ul style="list-style-type: none"> • Bariatric surgery (<u>preauthorization</u> required to avoid a \$250 penalty) • Chiropractic care (limited to 30 visits per year and supplies are not covered) 	<ul style="list-style-type: none"> • 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 1-800-662-0547 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 1-800-662-0547.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-662-0547.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-662-0547.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-662-0547.

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

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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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$170
Copayments	\$10
Coinsurance	\$540
<i>What isn't covered</i>	
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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$170
Copayments	\$340
Coinsurance	\$110
<i>What isn't covered</i>	
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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$170
Copayments	\$0
Coinsurance	\$440
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$610