




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, <https://eoc.anthem.com/eocdps/ca/fi>. 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/](http://www.healthcare.gov/sbc-glossary/) or call (800) 627-5342 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0.	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	A <a href="#">deductible</a> does not apply.	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<i>For covered medical services from Participating Providers (in the CA Care Network): \$1,500/individual or \$4,500/family</i> <i>For prescription drugs (excluding injectable drugs provided by the Fund): \$6,650 individual / \$11,800 family.</i>	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Copayments</a> for certain services, expenses for non- <a href="#">formulary</a> drugs without a PBM-approved medical exception, expenses for Non-Preferred MPD drugs, <a href="#">Copayments</a> and <a href="#">Coinsurance</a> from non-participating <a href="#">Providers</a> , <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if	Yes, the Blue Cross HMO (CA	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's</a>

you use a <a href="#">network provider</a> ?	Care) Network. See <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> or call (800) 627-5342 for a list of <a href="#">network providers</a> . For Mental Health and/or Substance use services, call HMC at 1-800-461-9179 or see <a href="http://www.hmc.healthworks.com">www.hmc.healthworks.com</a>	<a href="#">network</a> . You will pay the most if you use an out-of- <a href="#">network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an out-of- <a href="#">network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes.	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .

 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
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$35/visit	Not covered	If you receive services in addition to office visit, additional <a href="#">Copayment</a> or <a href="#">Coinsurance</a> may apply.
	<a href="#">Specialist</a> visit	\$45/visit	Not covered	Member is required to obtain a <a href="#">referral</a> to <a href="#">Specialist</a> or other licensed health care practitioner, except for OB/GYN <a href="#">Physician Services</a> within the Participating medical group and Emergency/Urgently needed <a href="#">Services</a> . If you receive <a href="#">Services</a> in addition to office visit, additional <a href="#">Copayment</a> or <a href="#">Coinsurance</a> may apply.
	<a href="#">Preventive care</a> / <a href="#">screening</a> /immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	-----none-----
If you need drugs to treat your	Formulary Generic drugs	Preferred MPD and Non-MPD Drugs:	Not covered	Coverage by Prescription Drug Program through OptumRx. Copay

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/ca/fi>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>illness or condition</b> More information about <a href="http://www.optumrx.com">prescription drug coverage</a> is available at <a href="http://www.optumrx.com">http://www.optumrx.com</a>		\$10/prescription (\$7 for certain maintenance drugs). Non-preferred MPD Drugs: applicable copay plus the cost difference between the Non-Preferred Drug and the Preferred Drug. <u>Deductible</u> does not apply.		shown for a 30-day supply. Up to 90-day supply can be obtained for 2 copays. Market Priced Drug (MPD) program applies to certain drug classes; encourages use of lower cost alternatives. Higher cost if you use Non-Preferred MPD drug, unless you qualify for exception.  Certain maintenance medications used to treat hypertension, high cholesterol, diabetes, osteoporosis, glaucoma and asthma are eligible for reduced copays.
	Formulary Brand drugs	Preferred MPD and Non-MPD Drugs: \$20/prescription (\$15 for certain maintenance drugs). Non-preferred MPD Drugs: applicable copay plus the cost difference between the Non-Preferred Drug and the Preferred Drug. <u>Deductible</u> does not apply.	Not covered	For self-injectables not provided through Anthem Blue Cross: you pay 20% <u>coinsurance</u> plus any charges above the <u>allowed amount</u> . Contact the Fund office for more information.  Emergency benefits for Out-of- <u>Network</u> pharmacies: you pay applicable copay plus \$25 and any charges above <u>allowed amount</u> . No charge for FDA approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate).
	Non-Formulary drugs	Preferred MPD and Non-MPD Drugs: \$35/prescription (\$25 for certain maintenance drugs). Non-preferred MPD Drugs: applicable copay plus the cost difference between the Non-Preferred Drug and the Preferred Drug. <u>Deductible</u> does not apply.	Not covered	
	<u>Specialty</u> drugs	No charge if covered by Anthem Blue Cross	Not covered	

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$200/visit	Not covered	-----none-----
	Physician/surgeon fees	No charge	Not covered	-----none-----
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$150/visit	Covered as In- <a href="#">Network</a>	Copay waived if admitted. No charge for Emergency Room Physician Fee.
	<a href="#">Emergency medical transportation</a>	\$100/trip	Covered as In- <a href="#">Network</a>	-----none-----
	<a href="#">Urgent care</a>	\$35/visit	\$75/visit	If you receive services in addition to office visit, additional <a href="#">Copayment</a> or <a href="#">Coinsurance</a> may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$750/admission	Not covered	-----none-----
	Physician/surgeon fees	No charge	Not covered	-----none-----
If you need mental health, behavioral health, or substance abuse services contact HMC Health Works: <a href="https://hmc.personaladvantage.com">https://hmc.personaladvantage.com</a> or call 1-800-461-9179	Outpatient services	Office Visit \$25/visit Group session: \$12.50/session Other Outpatient services: \$25/visit	Office Visit Not covered Other Outpatient services Not covered	You must use an HMC provider or no coverage. You should confirm that your provider is in HMC's network before you obtain services. To do so, call HMC at 1-800-461-9179 or see <a href="http://www.hmc.healthworks.com">www.hmc.healthworks.com</a>
	Inpatient services	\$500/admission	Not covered	Precertification from HMC is required for all inpatient services, except emergency hospitalization. No Coverage for services not authorized by HMC.
If you are pregnant	Office visits	No charge	Not covered	<a href="#">Cost sharing</a> does not apply to preventive services. Depending on the type of services, additional <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	\$750/admission	Not covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	\$35/visit	Not covered	100 visits/benefit period.
	<a href="#">Rehabilitation services</a>	\$35/visit	Not covered	*See Therapy Services section You pay 100% for <a href="#">habilitation</a> services, even with a Participating <a href="#">Provider</a> .
	<a href="#">Habilitation services</a>	Not covered	Not covered	
	<a href="#">Skilled nursing care</a>	\$750/admission	Not covered	100 days limit/benefit period.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	<a href="#">Durable medical equipment</a>	No charge	Not covered	-----none-----
	<a href="#">Hospice services</a>	No charge	Not covered	If inpatient admission, subject to inpatient <a href="#">copayments</a> .
If your child needs dental or eye care	Children's eye exam	\$35/visit	Not covered	Anthem- Benefits available to age 26. Limited benefit also available through the Fund's separate vision program.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Anthem- None Fund- Benefits available under separate Indemnity Dental <a href="#">Plan</a> or prepaid Dental <a href="#">Plan</a> .

**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) – (coverage available under separate Indemnity Dental [Plan](#) or prepaid Dental [Plan](#))
- [Habilitation services](#)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care unless you have been diagnosed with diabetes.
- Weight loss programs

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

- Acupuncture (annual benefit maximum of \$1,000 combined with chiropractic care. Provided through Fund).
- Bariatric surgery
- Chiropractic care (annual benefit maximum of \$1,000 combined with acupuncture. Provided through Fund).
- Hearing aids (\$5,000 maximum/ear every 36 months)
- Routine eye care (Adult) (Coverage for glasses and contacts is limited to Fund provided annual benefit maximum of \$150 for exam frames, and lenses).

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/ca/fi>.

**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: Department of Managed Health Care, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, (888) HMO-2219. Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [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 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:

ATTN: [Grievances](#) and [Appeals](#), P.O. Box 4310, Woodland Hills, CA 91365-4310

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

California Department of Managed Health Care Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814, (888) 466-2219, [www.healthhelp.ca.gov](http://www.healthhelp.ca.gov), [helpline@dmhc.ca.gov](mailto:helpline@dmhc.ca.gov)

**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-(800) 627- 5342

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*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](#) \$0
- [Specialist copayment](#) \$45
- Hospital (facility) [copayment](#) \$750
- Other [coinsurance](#) 0%

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
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In this example, Peg would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$860
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$920</b>

**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](#) \$45
- Hospital (facility) [copayment](#) \$750
- Other [coinsurance](#) 0%

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
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In this example, Joe would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$782
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$837</b>

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$45
- Hospital (facility) [copayment](#) \$750
- Other [coinsurance](#) 0%

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
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In this example, Mia would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$575
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$575</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

## Language Access Services:

(TTY/TDD: 711)

**Spanish (Español):** Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (800) 627-5342.

### **It's important we treat you fairly**

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.