Anthem Blue Cross:
HMO / CA-Care – Plan B – Platinum Plus
UFCW Unions & Food Employers Benefit Fund

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/ or call (800) 627-5342 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?	A deductible does not apply.	See the Common Medical Events chart below for your costs for services this plan covers.
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?	***For covered medical services from Participating Providers (in the CA Care Network):*** **$1,500**/individual or **$4,500**/family. ***For prescription drugs (excluding injectable drugs provided by the Fund):*** **$6,650** individual / **$11,800** 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?	Copayments for certain services, expenses for non-formulary drugs without a PBM-approved medical exception, expenses for Non-Preferred MPD drugs, Copayments and Coinsurance from non-participating Providers, Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network	Yes, the Blue Cross HMO (CA Care) Network. See www.anthem.com/ca or call	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

provider?	(800) 627-5342 for a list of network providers. For Mental Health and/or Substance use services, call HMC at 1-800-461-9179 or see www.hmc.healthworks.com	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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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 provider's 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 Copayment or Coinsurance may apply.
	Specialist visit	$45/visit	Not covered	Member is required to obtain a referral to Specialist or other licensed health care practitioner, except for OB/GYN Physician Services within the Participating medical group and Emergency/Urgently needed Services. If you receive Services in addition to office visit, additional Copayment or Coinsurance may apply.
	Preventive care/screening/ immunization	No charge	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.
If you have a test	Diagnostic test (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 illness or condition	Formulary Generic drugs	Preferred MPD and Non-MPD Drugs: $10/prescription ($7 for certain maintenance drugs).	Not covered	Coverage by Prescription Drug Program through OptumRx. Copay shown for a 30-day supply. Up to 90-day supply can be obtained for 2 copays. Market Priced Drug (MPD)

* 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)	
More information about **prescription drug coverage** is available at http://www.optumrx.com		Non-preferred MPD Drugs: applicable copay plus the cost difference between the Non-Preferred Drug and the Preferred Drug. Deductible does not apply.		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. For self-injectables not provided through Anthem Blue Cross: you pay 20% coinsurance plus any charges above the allowed amount. Contact the Fund office for more information. Emergency benefits for Out-of-Network pharmacies: you pay applicable copay plus $25 and any charges above allowed amount. No charge for FDA approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate).
	Formulary Brand drugs	Preferred MPD and Non-MPD Drugs: $25/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. Deductible does not apply.	Not covered	
	Non-Formulary drugs	Preferred MPD and Non-MPD Drugs: $40/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. Deductible does not apply.	Not covered	
	Specialty drugs	No charge if covered by Anthem Blue Cross	Not covered	
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--------

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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 need immediate medical attention	Emergency room care	$150/visit	Covered as In-Network	Copay waived if admitted. No charge for Emergency Room Physician Fee.
	Emergency medical transportation	$100/trip	Covered as In-Network	--------none--------
	Urgent care	$35/visit	$75/visit	If you receive services in addition to office visit, additional Copayment or Coinsurance 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: https://hmc.personaladvantage.com 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 www.hmc.healthworks.com
	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	Cost sharing does not apply to preventive services. Depending on the type of services, additional copayment or coinsurance 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	Home health care	$35/visit	Not covered	100 visits/benefit period.
	Rehabilitation services	$35/visit	Not covered	*See Therapy Services section You pay 100% for habilitation services, even with a Participating Provider.
	Habilitation services	Not covered	Not covered	
	Skilled nursing care	$750/admission	Not covered	100 days limit/benefit period.
	Durable medical equipment	No charge	Not covered	--------none--------
	Hospice services	No charge	Not covered	If inpatient admission, subject to inpatient copayments.

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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 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 Plan or prepaid Dental Plan.

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. 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:

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

California Department of Managed Health Care Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814, (888) 466-2219, www.healthhelp.ca.gov, 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 (Espanol): Para obtener asistencia en Espanol, llame al-(800) 627- 5342

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

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/ca/fi.

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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$/92
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$920**

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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$782
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$837**

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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$575
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$575**

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.