**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 call 1-800-320-0106. 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 https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 1-800-320-0106 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $200 person/$600 family for in-network benefits; $1,000 per person (no per family deductible) for out-of-network benefits. | 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. The Annual Deductible does not apply to acupuncture, chiropractic services, in-network emergency room services, and office visits or preventive services by network providers. | 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?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Yes, $5,000 person/$10,000 family for in-network medical benefits, and $1,600 person/$3,200 family for in-network prescription drug benefits per calendar year. No limit out-of-network. | 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?** | Premiums, balance-billing charges, penalties for failure to obtain preauthorization for services, 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 provider?** | Yes. For a list of network providers, see www.anthem.com/ca or call (800) 759-3030. | 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 |
|---|---|---|---|---|
| | | 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 | $20 copay per visit | 50% coinsurance (of UCR (Usual, Customary and Reasonable)) | Non-emergency services provided by a non-PPO provider at a PPO facility is limited to 10% coinsurance, unless you consent to the non-PPO billing rates. A covered visit includes a telephone or video visit with your doctor. |
| | Specialist visit | $40 copay per visit | 50% coinsurance (of UCR) | Non-emergency services provided by a non-PPO provider at a PPO facility is limited to 10% coinsurance, unless you consent to the non-PPO billing rates. A covered visit includes a telephone or video visit with your doctor. |
| | Preventive care/screening/ immunization | No Charge | 50% coinsurance (of UCR) | 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) | 10% coinsurance (of contract rate) | 50% coinsurance (of UCR) | None |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance (of contract rate) | 50% coinsurance (of UCR) | |


** To the extent required under the federal No Surprises Act, out-of-network provider services will be covered at the copay and coinsurance rates applicable to in-network provider services, and balance billing will not apply.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at www.optumrx.com. | Generic drugs (Tier 1) | Retail: $10 copay / prescription<br>Mail: $25 copay / prescription | Not covered | Covers up to a 30-day supply (retail), and up to a 90-day supply (mail order). Retail and mail order available through OptumRx only.<br><br>Certain compound medications are excluded from coverage (i.e., non-FDA approved bulk chemicals, bulk chemicals for vitamins/supplements typically available over-the-counter, products for cosmetic uses, and ingredients used in compounding topical formulations not approved by the FDA for this route of administration).<br><br>Any covered compound medications costing $150 or more require prior authorization from OptumRx. |
| | Preferred brand drugs (Tier 2) | Retail: $35 copay / prescription<br>Mail: $87.50 copay / prescription | Not covered | |
| | Non-preferred brand drugs (Tier 3) | Retail: 60% coinsurance<br>Mail: 60% coinsurance | Not covered | |
| | Specialty drugs (Tier 4) | 20% coinsurance up to $100 maximum | Not covered | Prior authorization from OptumRx is required. For specialty drug prior authorization please call (800) 711-4555.<br><br>You must fill your specialty prescriptions through BriovaRx, OptumRx's specialty pharmacy. Please call 1-855-4BRIOVA (1-855-427-4682) to enroll. You can also register online at https://briovarx.com/newpatient. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance (of contract rate) | 50% coinsurance (of UCR) | Non-emergency services provided by a non-PPO provider at a PPO facility is limited to 10% coinsurance, unless you consent to the non-PPO billing rates. $1,000 maximum out-of-network facility benefits per date of service. |
| | Physician/surgeon fees | $50 copay per procedure then 10% coinsurance (of contract rate) | 50% coinsurance (of UCR) | For network providers, $20 copay (attending physician)/$40 copay (specialist) instead of $50 if surgery is performed in a physician's office with no facility fee. Non-emergency services provided by a non-PPO provider at a PPO facility is limited to 10% coinsurance, unless you consent to the non-PPO billing rates. |
| **If you need immediate medical attention** | Emergency room care | $100 copay / visit then 10% coinsurance (of contract rate) | 10% coinsurance (of UCR) | You will have to pay 50% co-insurance for emergency services at a non-PPO facility if (1) you did not have an emergency medical condition; or (2) you receive emergency services for treatment of an emergency medical condition from a non-PPO provider or non-PPO emergency facility and consent to the non-PPO billing rate for certain post-stabilization services. |
| | Emergency medical transportation | $50 copay / trip | 50% coinsurance (of UCR) for air transport; $50 copay / trip for ground transportation | $5,000 maximum benefit for ground transportation. Only covered if medically necessary. |
| | Urgent care | $20 copay then 10% coinsurance (of contract rate) | 50% coinsurance (of UCR) | Coinsurance for urgent care is limited to UCR for physician's initial office visit. |

[* For more information about limitations and exceptions, see the plan or policy document at https://www.ourbenefitoffice.com/oelocal501/benefits/HealthcareDocuments.aspx]

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance (of contract rate) | $600 copay then 50% coinsurance (of UCR) | Inpatient admissions must be preauthorized or benefits will be further reduced by 50%. If using an inpatient network facility, certain services will be based on the network provider benefit even if some services during the inpatient stay are rendered by an out-of-network provider and the choice was beyond your control. In some instances, services provided by an out-of-network provider at a network facility may be payable at the network coinsurance. Non-emergency services provided by a non-PPO provider at a PPO facility is limited to 10% co-insurance, unless you consent to the non-PPO billing rates. |
| | Physician/surgeon fees | $50 copay then 10% coinsurance (of contract rate) | 50% coinsurance (of UCR) | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $20 copay / visit | 50% coinsurance (of UCR) | Mental health and substance use disorder benefits available to active employees and their dependents only. To schedule an appointment with an EAP counselor for in-person or virtual sessions, please contact Anthem EAP by calling **(800) 999-7222** or by visiting www.**anthemEAP.com** **and enter login: OELocal501**. Inpatient admissions must be preauthorized or benefits will be further reduced by 50%. For preauthorization for inpatient services and benefits, contact Anthem at 1-800-274-7767. Non-emergency services provided by a non-PPO provider at a PPO facility is limited to 10% co-insurance, unless you consent to the non-PPO billing rates. |
| | Inpatient services | 10% coinsurance (of contract rate) | $600 copay then 50% coinsurance (of UCR) | |
| **If you are pregnant** | Office visits | $20 copay per visit | 50% coinsurance (of UCR) | Routine newborn care at non-network hospitals is not covered. In some instances, services provided by an out-of-network provider at a network facility may be payable at the network coinsurance. |
| | Childbirth/delivery professional services | $50 copay then 10% coinsurance (of contract rate) | 50% coinsurance (of UCR) | |
| | Childbirth/delivery facility services | 10% coinsurance (of contract rate) | $600 copay then 50% coinsurance (of UCR) | |

[* For more information about limitations and exceptions, see the plan or policy document at https://www.ourbenefitoffice.com/oelocal501/benefits/HealthcareDocuments.aspx]

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need help recovering or have other special health needs** | Home health care | $20 copay /visit then 10% coinsurance (of contract rate) | 50% coinsurance (of UCR) | Home health care is limited to 40 visits/year (limit does not apply if it is authorized in lieu of hospitalization). |
| | Rehabilitation services | $20 copay / session | 50% coinsurance (of UCR) | Inpatient and outpatient rehabilitation services. |
| | Habilitation services | Not covered | Not covered | None |
| | Skilled nursing care | 10% coinsurance (of contract rate) | $600 copay then 50% coinsurance (of UCR) | Coverage is limited to 60 days/year. Out-of-network inpatient admission copay applies unless transferred directly from a hospital. Inpatient admissions must be preauthorized or benefits will be further reduced by 50%. |
| | Durable medical equipment | 10% coinsurance (of contract rate) | 50% coinsurance (of UCR) | Durable medical equipment over $1,000 must be preauthorized or benefits will be further reduced by 50%. |
| | Hospice services | Inpatient: 10% coinsurance (of contract rate)<br>In home: $20 copay /visit then 10% coinsurance (of contract rate) | Inpatient: $600 copay then 50% coinsurance (of UCR)<br>In home: 50% coinsurance (of UCR) | Out-of-network inpatient admission copay applies unless transferred directly from a hospital.<br>Respite Care: maximum of $1,500 for inpatient per disability, maximum of $1,000 for outpatient per disability. |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | Not covered | Not covered under the Indemnity Medical Plan, may be available under the Vision Care Plan as applicable, if you are eligible. Vision benefits are available for active participants and their dependents only. |
| | Children's glasses | Not covered | Not covered | Not covered under the Indemnity Medical Plan, may be available under the Vision Care Plan as applicable, if you are eligible. Vision benefits are available for active participants and their dependents only. |
| | Children's dental check-up | Not covered | Not covered | Not covered under the Indemnity Medical Plan, may be available under the Indemnity Dental Plan or Dental HMO plan as applicable. |

[* For more information about limitations and exceptions, see the plan or policy document at https://www.ourbenefitoffice.com/oelocal501/benefits/HealthcareDocuments.aspx]

## 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.)**

- Bariatric Surgery (may be covered if certain requirements are met)
- Cosmetic Surgery
- Habilitation Services
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Non-medically necessary services/treatment
- Private Duty Nursing
- Routine Foot Care
- Weight Loss Programs

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

- Acupuncture
- Chiropractic Care
- ABA therapy
- Dental Care (Adult), if eligible for dental benefits through the Dental Plan (i.e., dental care is not available through the Indemnity Medical Plan)
- Hearing Aids
- Routine eye care (Adult), if eligible for vision benefits through the Vision Care Plan (i.e., vision care is not available through the Indemnity Medical Plan)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. You may contact the Health Plan at: 1-800-320-0106. You may also contact your state insurance department, the U.S. Department of Labor, 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 Insruance 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: you can contact the plan at 1-800-320-0106. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or at www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file you appeal. Contact the California Department of Insurance at 1-800-927-4357.

**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 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 [1-800-320-0106].

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [1-800-320-0106].

Chinese (中文): 如果需要中文的帮助，请拨打这个号码[1-800-320-0106].

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [1-800-320-0106].

*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 the plan or policy document at https://www.ourbenefitoffice.com/oelocal501/benefits/HealthcareDocuments.aspx]

## 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 | $200 |
| Specialist copayment | $40 |
| 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 | $200 |
| Copayments | $100 |
| Coinsurance | $1,100 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,460** |

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

| | |
|---|---|
| The plan's overall deductible | $200 |
| Specialist copayment | $40 |
| 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 | $200 |
| Copayments | $300 |
| Coinsurance | $700 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,220** |

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

| | |
|---|---|
| The plan's overall deductible | $200 |
| Specialist copayment | $40 |
| Hospital (facility) coinsurance | 10% |
| 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 | $200 |
| Copayments | $100 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$400** |

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