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 1-619-849-1060 or visit us at www.ourbenefitoffice.com/SanDiegoUnite. 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 1-619-849-1060 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$100** person/**$300** family Does not apply to preventive care services, prescription drug benefits and other medical care services requiring a copayment.	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. Preventive care and benefits with copayments 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. 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?	Yes. **$50** per person for home health care.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For PPO providers **$6,350** per person; **$12,700** per family. For non-PPO providers there are no out-of-pocket limits.	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, and health care this plan doesn't cover, and any non-PPO charges you pay.	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. See **www.anthem.com/ca/ or call 1-800-759-3030** for a list of network (PPO) 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; however, if you receive a referral from the Family Health Center, the copayment will be waived (see below).

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 copayment/visit. Deductible does not apply. No copayment at the Family Health Center.	50% coinsurance	Acupuncture services are covered if prescribed for rehabilitation purposes only and are subject to a $750/40 visit annual limit. There is no copayment at the Family Health Center for primary care office visits.
	Specialist visit	$20 copayment/visit. Deductible does not apply. No copayment with referral from the Family Health Center.	50% coinsurance	If you designate the Family Health Center as your primary care physician and are referred to a specialist, the copayment is waived.
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	50% coinsurance	For non-PPO providers, this plan pays up to $135 per exam. 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; $0 for preventive tests. (Certain tests at no cost at Family Health Center)	50% coinsurance	Certain tests will be available at no cost when the participant is treated at the Family Health Center.
	Imaging (CT/PET scans, MRIs)	10% coinsurance; $0 for preventive imaging. (Certain tests at no cost when referred by Family Health Center)	50% coinsurance	Some tests may be available at no cost if participant is referred by the Family Health Center to a designated facility.

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 More information about **prescription drug coverage** is available at http://unitehere30benefits.org	Generic drugs	$15 copayment retail or mail order. Deductible does not apply. Certain drugs available at no cost at Family Health Center.	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription) Certain generic drugs will be available at no cost at Family Health Center. The list of drugs covered at no charge may change from time to time.
	Preferred brand drugs	If no generic is available: $30 copayment retail or mail order. If generic is available: $30 copayment plus the cost difference between the generic and brand name drug. Deductible does not apply. Certain drugs may be available at no cost at Family Health Center.	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). The following classes of brand drugs require trial and failure of at least one generic: statins, SSRI antidepressants, ARB/ACE, sleep aids, proton pump inhibitors. Certain brand drugs may be available at no cost at the Family Health Center. The list of drugs covered at no charge may change from time to time.
	Specialty drugs	$15/$30 copayment. Deductible does not apply.	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Pre-authorization is required.

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 (Facility and Physician fees capped at $375 if Family Health Center is designated as primary physician)	50% coinsurance	None
	Physician/surgeon fees	10% coinsurance (Facility and Physician fees capped at $375 if Family Health Center is designated as primary physician)	50% coinsurance	–In some instances, services provided by an out of network provider at an in-network facility may be payable with a 10% coinsurance amount.
If you need immediate medical attention	Emergency room care	$100 copayment if medically necessary. Copayment waived if admitted.	$100 copayment if medically necessary. Copayment waived if admitted.	$250 copayment plus 10% of charges in excess of $250 will apply if a PPO emergency room is used for a medical condition not considered a true emergency (treatment could have been provided by an Urgent Care or Retail Store Clinic). For non-PPO providers, 50% coinsurance if not for emergency care.
	Emergency medical transportation	20% coinsurance	20% coinsurance	For non-PPO providers, 50% coinsurance if not for emergency care.
	Urgent care	Urgent Care Center $20 copayment/visit; deductible does not apply. Retail Store Clinic (CVS) - $10 copayment/visit; deductible does not apply.	50% coinsurance	None

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)	$500 hospitalization copayment for authorized stays; deductible does not apply.	Plan Pays: Room and Board: $135 per day for Employee; $100 per day for Dependents. Intensive Care: $405 per day for Employees and $300 per day for Dependents. Ancillary charges: 50% coinsurance	Hospital stays must be preauthorized or there will be a $1,000 penalty for not obtaining a preauthorization.
	Physician/surgeon fees	10% coinsurance (capped at $250 if Family Health Center is designated as primary physician).	50% coinsurance	Coinsurance is capped at $250 maximum if the Family Health Center is designated as the Participant's primary physician, so that the out-of-pocket cost for the facility fee and coinsurance will not exceed $750.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	50% coinsurance	None
	Inpatient services	$500 hospitalization copayment for authorized stays; deductible does not apply. Physician fees: 10% coinsurance (capped at $250 if Family Health Center is designated as primary physician).	For Mental/Behavioral Health, plan pays: Room and Board: $135 per day for Employee; $100 per day for Dependents. Intensive Care: $405 per day for Employees and $300 per day for Dependents. Ancillary charges: 50% coinsurance	Coinsurance is capped at $250 maximum if the Family Health Center is designated as the Participant's primary physician, so that the out-of-pocket cost for the facility fee and coinsurance will not exceed $750.

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 are pregnant	Office visits	10% coinsurance ($0 for preventive services)	50% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). Depending on the type of services, a coinsurance and deductible may apply.
	Childbirth/delivery professional services	10% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	$500 copay per hospital stay; deductible does not apply.	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	20% coinsurance	Separate $50 deductible per person
	Rehabilitation services	$20 copay/visit; deductible does not apply	50% coinsurance	None
	Habilitation services	$20 copay/visit; deductible does not apply	50% coinsurance	None
	Skilled nursing care	$500 hospitalization copay for authorized stays; deductible does not apply	Plan Pays: Room and Board: $135 per day for Employee; $100 per day for Dependents. Intensive Care: $405 per day for Employees and $300 per day for Dependents. Ancillary charges: 50% coinsurance	Maximum of 60 days per disability
	Durable medical equipment	10% coinsurance	50% coinsurance	None
	Hospice services	10% coinsurance	50% coinsurance	None
If your child needs dental or eye care	Children's eye exam	$0	$5 copay, plan pays up to $45	Limited to one exam every 12 months
	Children's glasses	$15 copay, plan pays up to $120	$15 copay, plan pays up $45	Limited to one set of glasses every 24 months
	Children's dental check-up	$0	$0, provided $50 deductible is met	Plan pays 100% up to the schedule limit for preventive services

[* For more information about limitations and exceptions, see the plan or policy document at www.ourbenefitoffice.com/SanDiegoUnite

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)
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

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

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Weight loss programs

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 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 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 San Diego UNITE HERE Health Fund, 3737 Camino Del Rio South, Ste. #300 San Diego, CA 92108 or call 1-619-849-1060. 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 1-619-574-1685.

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 www.ourbenefitoffice.com/SanDiegoUnite

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	$100
Specialist copayment	$20
Hospital (facility) copayment	$500
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	**$11,540**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$100
Copayments	$500
Coinsurance	$500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,160**

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

The plan's overall deductible	$100
Specialist copayment	$20
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	**$4,700**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$700
Coinsurance	$80
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$900**

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

The plan's overall deductible	$100
Specialist copayment	$20
Hospital (facility) copayment	$100
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	**$2,300**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$100
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$500**

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