




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 Doesn't 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 family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copayment</u> /visit. <u>Deductible</u> does not apply. No <u>copayment</u> at the Family Health Center.	50% <u>coinsurance</u>	Acupuncture services are covered if prescribed for <u>rehabilitation</u> purposes only and are subject to a \$750/40 visit annual limit. There is no <u>copayment</u> at the Family Health Center for <u>primary care</u> office visits.
	<u>Specialist</u> visit	\$20 <u>copayment</u> /visit. <u>Deductible</u> does not apply. No <u>copayment</u> with <u>referral</u> from the Family Health Center.	50% <u>coinsurance</u>	If you designate the Family Health Center as your <u>primary care physician</u> and are referred to a <u>specialist</u> , the <u>copayment</u> is waived.
	<u>Preventive care/screening/immunization</u>	No charge. <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	For <u>non-PPO providers</u> , this <u>plan</u> pays up to \$135 per exam. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u> ; \$0 for <u>preventive</u> tests (Certain tests at no cost at Family Health Center)	50% <u>coinsurance</u>	Certain tests will be available at no cost when the participant is treated at the Family Health Center.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u> ; \$0 for <u>preventive</u> imaging (Certain tests at no cost when referred by Family Health Center)	50% <u>coinsurance</u>	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	\$10 <u>copayment</u> retail or mail order. <u>Deductible</u> 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: 20% <u>coinsurance</u> minimum of \$15 retail or mail order. If generic is available: \$15 <u>copayment</u> plus the cost difference between the generic and brand name drug. <u>Deductible</u> 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	20% <u>coinsurance</u> minimum of \$15 retail or mail order. <u>Deductible</u> does not apply.	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). <u>Pre-authorization</u> 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% <u>coinsurance</u> (Facility and Physician fees capped at \$375 if Family Health Center is designated as <u>primary physician</u>)	50% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u> (Facility and Physician fees capped at \$375 if Family Health Center is designated as <u>primary physician</u>)	50% <u>coinsurance</u>	–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 <u>copayment</u> if <u>medically necessary</u> . <u>Copayment</u> waived if admitted.	\$100 <u>copayment</u> if <u>medically necessary</u> . <u>Copayment</u> waived if admitted.	\$250 <u>copayment</u> 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 <u>emergency</u> (treatment could have been provided by an <u>Urgent Care</u> or Retail Store Clinic). For <u>non-PPO providers</u> 50% <u>coinsurance</u> if not for <u>emergency care</u> .
	Emergency medical transportation	20% <u>coinsurance</u>	20% <u>coinsurance</u>	For <u>non-PPO providers</u> , 50% <u>coinsurance</u> if not for <u>emergency care</u> .
	Urgent care	<u>Urgent Care</u> Center \$20 <u>copayment/visit</u> ; <u>deductible</u> does not apply. Retail Store Clinic (CVS) - \$10 <u>copayment/visit</u> ; <u>deductible</u> does not apply.	50% <u>coinsurance</u>	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 <u>copayment</u> for authorized stays; <u>deductible</u> 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% <u>coinsurance</u>	Hospital stays must be preauthorized or there will be a \$1,000 penalty for not obtaining a <u>preauthorization</u> .
	Physician/surgeon fees	10% <u>coinsurance</u> (capped at \$250 if Family Health Center is designated as <u>primary physician</u>).	50% <u>coinsurance</u>	<u>Coinsurance</u> is capped at \$250 maximum if the Family Health Center is designated as the Participant's <u>primary physician</u> , so that the out-of-pocket cost for the facility fee and <u>coinsurance</u> will not exceed \$750.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Inpatient services	\$500 <u>hospitalization copayment</u> for authorized stays; <u>deductible</u> does not apply. Physician fees: 10% <u>coinsurance</u> (capped at \$250 if Family Health Center is designated as <u>primary physician</u>).	For Mental/Behavioral Health, <u>plan</u> 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% <u>coinsurance</u> For Substance Abuse Disorders: 50% <u>coinsurance</u>	<u>Coinsurance</u> is capped at \$250 maximum if the Family Health Center is designated as the Participant's <u>primary physician</u> , so that the out-of-pocket cost for the facility fee and <u>coinsurance</u> 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% <u>coinsurance</u> (\$0 for <u>preventive services</u>)	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). Depending on the type of service, a <u>coinsurance</u> and <u>deductible</u> may apply.
	Childbirth/delivery professional services	10% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$500 <u>copay</u> per hospital stay; <u>deductible</u> does not apply.	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	Home health care	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Separate \$50 <u>deductible</u> per person
	Rehabilitation services	\$20 <u>copay</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	None
	Habilitation services	\$20 <u>copay</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	None
	Skilled nursing care	\$500 <u>hospitalization copay</u> for authorized stays; <u>deductible</u> 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% <u>coinsurance</u>	Maximum of 60 days per disability
	Durable medical equipment	10% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Hospice services	10% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If your child needs dental or eye care	Children's eye exam	\$0	\$5 <u>copay</u> , <u>plan</u> pays up to \$45	Limited to one exam every 12 months
	Children's glasses	\$15 <u>copay</u> , <u>plan</u> pays up to \$120	\$15 <u>copay</u> , <u>plan</u> pays up to \$45	Limited to one set of glasses every 24 months
	Children's dental check-up	\$0	\$0, provided \$50 <u>deductible</u> is met	<u>Plan</u> plays 100% up to the schedule limit for <u>preventive services</u>

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.—————

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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	\$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
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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	\$4,900
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$100
Copayments	\$500
Coinsurance	\$80
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$700

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
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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.