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, visit www.ualocal393benefits.org or call 408-588-3751. 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 http://cciio.cms.gov or call 408-588-3751 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$300** per person/ **$600** per family Doesn't apply to preventive care. Out-of network co-insurance and copays don't count toward the **deductible**	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there services covered before you meet your deductible?	No.	No benefits are paid on behalf of you or your family in a calendar year until you or your family has satisfied the applicable annual **deductible** requirement.
Are there other deductibles for specific services?	**$100** per ear for hearing aids There are no other specific **deductibles**	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?	**In-network $1,800** per person Out-of-network **No Limit**	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. If out-of-pocket expenses paid within the same calendar year exceed $1,800 per person, certain charges are excluded. Please refer to the Formal Plan Rules for a full list of exclusions.
What is not included in the out-of-pocket limit?	Premiums; Balanced-billed charges; Health Care this plan doesn't cover; deductibles; drug copays for a brand-name drug when a generic is available; most payments to non-PPO providers	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. **Please note, if you are treated by an out-of-network provider at an in-network facility, then your cost sharing amounts are limited to the in-network rate.**
Will you pay less if you use a network provider?	Yes. See www.anthem.com/ca or call 1-800-688-3828 for a list of participating providers	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart below for how this plan pays different kinds of **providers**.

Do you need a referral to see a specialist?	No, you don't need a referral to see a **specialist**.	You can see the **specialist** you choose without permission from this plan.



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	10% Coinsurance	40% Coinsurance	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.
	Specialist visit	10% Coinsurance	40% Coinsurance	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
	Preventive care/screening/ immunization	None	None	---none---
	Telehealth Services	10% Coinsurance	40% Coinsurance	Telehealth services outside of Anthem's LiveHealth Online program are covered the same as in person office visits. If you utilize Anthem LiveHealth Online, there is a $20 copayment for each visit.
If you have a test	Diagnostic test (blood work)	None	40% Coinsurance	---none--
	Imaging (CT/PET scans, MRIs; x-ray)	10% Coinsurance	40% Coinsurance	---none---
	COVID-19 Test or Antibody Treatment	10% Coinsurance	40% Coinsurance	The Plan only covers medically necessary COVID-19 testing. For out-of-network testing, the coinsurance will be applied to the usual customary and reasonable rate as determined by Plan Rules. You will be responsible for any amounts above this rate. Over-the-counter COVID-19 tests are not covered.

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.ualocal393benefits.org	Generic drugs	10% (minimum of $10/ max of $50)	N/A	If full price of drug is less than $10, then co-payment is the full price. Erectile Dysfunction 6 tablets per 30 days
	Preferred brand drugs	10% (minimum of $10/ max of $50)	N/A	If full price of drug is less than $10, then co-payment is the full price. Erectile Dysfunction 6 tablets per 30 days
	Non-preferred brand drugs	10% (minimum of $10) plus cost difference between brand and generic	N/A	If full price of drug is less than $10, then co-payment is the full price. Erectile Dysfunction 6 tablets per 30 days
	Specialty drugs	Same as above	N/A must be ordered through specialty pharmacy	Must be ordered from Navitus Lumicera.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance	40% Coinsurance	Ambulatory Surgery Centers for Non-PPO providers covered at 60% of the UCR charges up to a maximum of $350 per day. Such maximum shall apply to all fees incurred, except for out-of-network providers at an in-network facility. 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. Covered at 100% and eligible for ERA Credit incentive when services are provided at a **Global 1** Ambulatory Surgery Center.
	Physician/surgeon fees	10% Coinsurance	40% Coinsurance	
If you need immediate medical attention	Emergency room care	10% Coinsurance	10% Coinsurance	You will have to pay 40% **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	10% Coinsurance	10% Coinsurance	If you go to a non-PPO provider in a medical

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)	
	transportation			emergency, the Plan will pay the greater of (1) 90% of the UCR charges, (2) 90% of the applicable PPO rate, or (3)90% of the amount that would be paid under Medicare up to the Out-of-Pocket limit. After the Out-of-Pocket limit is reached, the Plan pays 100% of the applicable rate.
	Urgent care	10% Coinsurance	40% Coinsurance	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance	40% Coinsurance	---none---
	Physician/surgeon fees	10% Coinsurance	40% 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.
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	10% Coinsurance	40% Coinsurance	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. Health Advocate EAP also available
	Mental/Behavioral health inpatient services	10% Coinsurance	40% 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. Approved services through Beat It! are covered at 100%
	Substance use disorder outpatient services	None for 1st treatment/10% thereafter	40% Coinsurance	Health Advocate EAP also available.
	Substance use disorder inpatient services	None for 1st treatment/10% thereafter	40% Coinsurance	Approved services through Beat It! are covered at 100%
If you are pregnant	Office visits	10% Coinsurance	40% Coinsurance	---none---
	Childbirth/delivery professional services	10% Coinsurance	40% Coinsurance	---none---
	Childbirth/delivery facility services	10% Coinsurance	40% Coinsurance	---none---

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 need help recovering or have other special health needs	Home health care	10% Coinsurance	40% Coinsurance	100 visits per calendar year
	Rehabilitation services	10% Coinsurance	40% Coinsurance	Combined limit of 20 in-person visits for occupational/physical therapy. Additional in-person visits may be approved if determined by the Plan's independent medical consultant to be medically necessary. Virtual Physical Therapy through Hinge Health Covered at 100%
	Habilitation services	10% Coinsurance	40% Coinsurance	---none---
	Skilled nursing care	10% Coinsurance	40% Coinsurance	---none---
	Durable medical equipment	10% Coinsurance	40% Coinsurance	---none---
	Hospice services	10% Coinsurance	40% Coinsurance	---none---
If your child needs dental or eye care	Children's eye exam	$10 copay	Covered up to $45 without copay	VSP
	Children's glasses	Lenses in full after copay and frames up to allowed amount	Covered up to allowed amount	VSP
	Children's dental check-up	None	N/A	Delta Dental only

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 Care
- Infertility Treatment (except intrauterine insemination)
- Behavioral Training (except if for ABA Therapy)
- Non-emergency care when traveling outside the U.S. and Canada
- Long Term Care
- Private Duty Nursing
- Injuries received while committing/attempting to commit illegal activity
- Concierge Care

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

- Acupuncture ($500 per calendar year)
- Bariatric Surgery (once per lifetime)
- Chiropractic Care (limited to 26 visits and $1,500 per calendar year)
- Organ Transplants
- Smoking Cessation Benefits (limited to 2 attempts per year)
- Long-Term Acute Hospital Benefits
- Home Infusion Therapy
- Elective Abortions
- Hearing Aids (after a separate $100 deductible per ear is paid, the Plan pays 80% of the PPO contract rate (or 60% of the usual customary and reasonable rate for Non-PPO providers)) up to $1,500 per device as medically necessary. This benefit is limited to one device per ear every three years.
- Routine Foot Care
- Routine Eye Care (through VSP)
- Cochlear Implants
- Dental Care (adult) (Maximum of $3,000 per covered person. Diagnostics and Preventive Care are not counted toward $3,000 maximum)
- Diabetes and Obesity Coaching
- Behavioral Interventions for Weight Management (for adult patients with a BMI of 30 kg/m2 or higher)
- ABA Therapy
- Speech Therapy (limited to 20 visits per year)
- Intrauterine Insemination

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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov.ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or www.cciio.cms.gov. 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 the Plan at 408-588-3770 or 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 408-588-3751.] [Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 408-588-3751.]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 408-588-3751.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 408-588-3751.]

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

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** **$300**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other (diagnostic tests; prescription drugs) 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)*
Prescription drugs

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$1,240
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,540**

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

- **The plan's overall deductible** **$300**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other (diagnostic tests) coinsurance** **0%**
- **Other (prescription drugs; durable medical equipment) coinsurance** **10%**
- **Virta Coaching** **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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$530
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$830**

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

- **The plan's overall deductible** **$300**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other (diagnostic tests) coinsurance** **10%**
- **Other (durable medical equipment; rehabilitation services) coinsurance** **10%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$250
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$550**

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