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 Employee Benefits at **559-353-6474**. 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.dol.gov/ebsa/healthreform or call **888-858-6427** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$600** individual / **$1,800** family for In-Network and Out-of-Network providers.	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, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-Network physician office visits, copayment delivery charges and prescription drugs 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.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services. See the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	**$2,000** individual / **$4,000** family for In-Network providers and **No limit** for Out-of-Network providers.	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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, copayments, deductible, prescription drugs, out-of-network services, pre-authorization penalties 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. See www.blueshieldca.com/networkppo or call 1-888-858-6427 for a list of network 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.	This plan will pay some or all of the costs to see a specialist for covered services

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	$15/visit – Deductible does not apply to office visit only. Deductible and 10% coinsurance for other services during office visit	40% coinsurance	——————none——————
	Specialist visit	$15/visit – Deductible does not apply to office visit only. Deductible and 10% coinsurance for other services during office visit	40% coinsurance	——————none——————
	Preventive care/screening/ immunization	$15/visit Deductible does not apply	40% coinsurance	——————none——————
If you have a test	Diagnostic test (x-ray, blood work, ultrasounds)	$15 copayment Deductible does not apply (Valley Children's Provider) Deductible and 10% coinsurance (other in-network providers)	40% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	$50 copayment Deductible does not apply (Valley Children's Provider) Deductible 10% coinsurance (other in-network providers)	40% coinsurance	——————none——————

For more information about limitations and exceptions, see plan or policy document on the George page or call Employee Benefits at (559) 353-6474.

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.caremark.com or call 877-217-1868	Generic drugs	$10/prescription (30-day supply) $20/prescription (90-day supply)		Covers up to a 30-day supply (retail prescription); 90-day supply (mail order or CVS pharmacy retail prescription). Maximum $1,000 per lifetime for drugs to treat infertility.
	Preferred brand drugs	20% coinsurance with Minimum $25/prescription (30-day supply) $40/prescription (90-day supply) and Maximum $50/prescription (30-day supply) $100/prescription (90-day supply)		
	Non-preferred brand drugs	30% coinsurance with Minimum $40/prescription (30-day supply) $80/prescription (90-day supply) and Maximum $200/prescription (30-day supply) $400/prescription (90-day supply)		
	Specialty drugs	Applicable copayment		Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	——————none——————
	Physician/surgeon fees	10% coinsurance	40% coinsurance	——————none——————
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance (emergency) 40% coinsurance (non-emergency)	——————none——————
	Emergency medical transportation	10% coinsurance	10% coinsurance (emergency) 40% coinsurance (non-emergency)	——————none——————
	Urgent care	$15/visit – Deductible does not apply to office visit only. Deductible and 10% coinsurance for other services during office visit	40% coinsurance	

For more information about limitations and exceptions, see plan or policy document on the George page or call Employee Benefits at (559) 353-6474.

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 (Valley Children's hospital only for NICU and PICU)	40% coinsurance	Pre-admission certification must be obtained in order to avoid a 50% reduction of benefits.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15/visit for office visit Deductible does not apply 10% coinsurance all other outpatient services	40% coinsurance	Intensive outpatient services require pre-certification.
	Inpatient services	10% coinsurance	40% coinsurance	Pre-admission certification must be obtained in order to avoid a 50% reduction of benefits.
If you are pregnant	Office visits	$15/first visit	40% coinsurance	Depending on the type of service, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	40% coinsurance	——————none——————
	Childbirth/delivery facility services	$250 copayment Deductible does not apply Deductible and 10% coinsurance (Community Medical Centers)	40% coinsurance	Pre-admission certification must be obtained for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay in order to avoid a 50% reduction of benefits.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	40% coinsurance	——————none——————
	Rehabilitation services	10% coinsurance	40% coinsurance	——————none——————
	Habilitation services	10% coinsurance	40% coinsurance	——————none——————
	Skilled nursing care	10% coinsurance	40% coinsurance	Services must begin within 14 days following a hospital confinement of at least 3 days.
	Durable medical equipment	10% coinsurance	40% coinsurance	Rental is covered up to the cost of purchase.
	Hospice services	10% coinsurance	40% coinsurance	——————none——————
	Children's eye exam	Not covered	Not covered	Not covered under the medical plan.

For more information about limitations and exceptions, see plan or policy document on the George page or call Employee Benefits at (559) 353-6474.

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 your child needs dental or eye care	Children's glasses	Not covered	Not covered	Not covered under the medical plan.
	Children's dental check-up	Not covered	Not covered	Not covered under the medical plan.

For more information about limitations and exceptions, see plan or policy document on the George page or call Employee Benefits at (559) 353-6474.

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
- Cosmetic surgery (except due to accidental injury, birth defect or illness or mastectomy)
- Dental care
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care
- 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 (prescription required)
- Chiropractic care (limited to $500 per calendar year)
- Hearing aids
- Infertility treatment (limited to $3,000 per lifetime)
- Private-duty nursing

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 plan at **888-858-6427,** your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 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 **888-858-6427**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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.

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 on the George page or call Employee Benefits at (559) 353-6474.

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	$600
Specialist *copayment*	$15
Hospital (facility) *copayment*	$250
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$600
Copayments	$430
Coinsurance	$1,152
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,242**

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

The plan's overall deductible	$600
Specialist *copayment*	$15
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$600
Copayments	$105
Coinsurance	$240
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,000**

Mia's Emergency Room Visit
(in-network emergency room visit and follow up care)

The plan's overall deductible	$600
Specialist *copayment*	$15
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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$600
Copayments	$45
Coinsurance	$163
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$808**