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?	**$0.**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	**Not applicable.**	This plan has no deductible. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	**No.**	You don't have to meet deductible for specific services.
What is the out-of-pocket limit for this plan?	**Individual $1,000** for In-Network Providers	The out-of-pocket limit is the most you could pay in a calendar year for covered services. If you have other family members on this plan, they must meet their own individual out-of-pocket limit. If the family out-of-pocket limit is met, the plan covers everyone on the plan at 100%. If only your individual max is met, 100% coverage applies to you only — not the whole family.
	Family $2,000 for In-Network Providers	
	No limit for Out-of-Network providers.	
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, 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 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.

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 visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit 20% coinsurance for additional services	40% coinsurance	Deductible does not apply to the office visit only. Deductible and 20% coinsurance for other services during office visit
	Specialist visit	$45 copay/visit 20% coinsurance for additional services	40% coinsurance	Deductible does not apply to the office visit only. Deductible and 20% coinsurance for other services during office visit
	Preventive care/screening/ immunization	No charge.	40% coinsurance	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, ultrasounds)	**Valley Children's Facilities** $15 copay **Other In-Network Providers** Deductible and 20% coinsurance	40% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	**Valley Children's Facilities** $50 copay **Other In-Network Providers** Deductible and 20% coinsurance	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 (minimum $25 to $100 maximum per prescription) – Retail 20% (minimum $50 to $200 maximum per prescription) – Mail Order		
	Non-preferred brand drugs	30% coinsurance (minimum $40 to $200 maximum per prescription) – Retail 30% coinsurance (minimum $80 to $400 maximum per prescription) – Mail Order		
	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)	20% coinsurance	40% coinsurance	None.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None.
If you need immediate medical attention	Emergency room care	$250 copay + 20% coinsurance		Copay waived if admitted.
	Emergency medical transportation	20% coinsurance		Non-emergency transport not covered.
	Urgent care	$20 copay/visit 20% coinsurance for other services during office visit	40% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% 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	20% coinsurance	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 mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit for office visit 20% coinsurance for all other outpatient services	40% coinsurance	Intensive outpatient services require pre-certification.
	Inpatient services	20% coinsurance	40% coinsurance	Pre-admission certification must be obtained in order to avoid a 50% reduction of benefits.
If you are pregnant	Office visits	$20 copay/per 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	20% coinsurance	40% coinsurance	None.
	Childbirth/delivery facility services	20% coinsurance	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	20% coinsurance	40% coinsurance	None.
	Rehabilitation services	20% coinsurance	40% coinsurance	None.
	Habilitation services	20% coinsurance	40% coinsurance	None.
	Skilled nursing care	20% coinsurance	40% coinsurance	Services must begin within 14 days following a hospital confinement of at least 3 days.
	Durable medical equipment	20% coinsurance	40% coinsurance	Rental is covered up to the cost of purchase.
	Hospice services	20% coinsurance	40% coinsurance	None.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered under the medical plan.
	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.

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 (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

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
- Bariatric Surgery/Weight Management

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 don't have Minimum Essential Coverage,for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

[Spanish (Español): Para obtener asistencia en Español, llame al 1-888-858-6427.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-858-6427.
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-858-6427.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-858-6427.

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	$0
Provider *copayment*	$20
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

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	$0
Copayments	$300
Coinsurance	$640
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,000**

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

The plan's overall deductible	$0
Specialist *copayment*	$45
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

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	$0
Copayments	$180
Coinsurance	$520
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$755**

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

The plan's overall deductible	$0
Specialist *copayment*	$45
Hospital (facility) *coinsurance*	$250 Copay + 10%
Other *coinsurance*	20%

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	$0
Copayments	$295
Coinsurance	$335
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$630**