




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, contact the Trust Fund Office at 1-800-527-4613. 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](http://www.dol.gov/ebsa/healthreform) or call 1-800-527-4613 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	Contract <u>providers</u> : \$250/individual or \$500/family Non-Contract <u>providers</u> : \$500/individual or \$1,500/family (interchangeable)	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your deductible?</b>	Yes. Contract <u>providers</u> : office visits (and physician home visits), <u>preventive care</u> , <u>prescription drugs</u> , x-ray & lab (unless performed at hospital), chiro, acupuncture, outpatient <u>rehabilitation services</u> , outpatient <u>habilitation services</u> , office visits for mental health and substance abuse, <u>urgent care</u> , emergency ground ambulance, podiatry exams, hearing exams/aids, <u>hospice services</u> and the supplemental accident benefit are covered before you meet your <u>deductible</u> .  Non-Contract <u>providers</u> : emergency ground ambulance, hearing exams/aids, <u>hospice services</u> , and supplemental accident are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	Medical <u>plan</u> contract <u>providers</u> : \$2,000/individual, \$4,000/family. <u>Prescription Drugs</u> In-Network: \$2,000/individual, \$4,000/family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.

Important Questions	Answers	Why This Matters:
What is not included in the <u>out-of-pocket limit</u> ?	<b>Medical plan:</b> deductible, premiums, balance-billing charges, penalties for failure to obtain <u>preauthorization</u> , skilled nursing facility, charges from Non-Contract providers, charges in excess of benefit maximums (including over MAC amounts), expenses for vision or dental care (if elected), outpatient <u>prescription drugs</u> , and health care this plan doesn't cover. <b>Prescription Drugs:</b> deductible, premiums, balance-billing charges, drugs this plan doesn't cover, charges from Non-Network pharmacies, and medical expenses.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.anthem.com">www.anthem.com</a> or call 1-800-274-7767 for a list of medical Contract providers. See <a href="http://www.mhn.com">www.mhn.com</a> or call 1-800-977-7962 for a list of Contract mental health and substance abuse providers.	This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your plan pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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
		Contract Provider (You will pay the least)	Non-Contract 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 (\$50 <u>copayment</u> /visit if you do not participate in the wellness program).	40% <u>coinsurance</u>	None.
	<u>Specialist</u> visit	<u>Deductible</u> does not apply.		
	<u>Preventive care/screening/Immunization</u>	No charge. <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	Age and frequency guidelines apply to covered <u>preventive care</u> . You may have to pay for services that aren't <u>preventive care</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Non-Contract Provider (You will pay the most)	
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	<b>Hospital:</b> 10% <u>coinsurance</u> .  <b>Other Facility:</b> \$20 <u>copayment</u> /test (\$50 <u>copayment</u> /test if you do not participate in the wellness program); <u>deductible</u> does not apply.	40% <u>coinsurance</u>	<u>Preauthorization</u> by Pacific Health Alliance (PHA) is required for genetic testing to avoid a 10% penalty. X-rays performed in your physician's office do not require <u>preauthorization</u> . Professional/physician charges may be billed separately.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> by PHA is required to avoid a 10% penalty. Professional/physician charges may be billed separately.
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.optumrx.com">www.optumrx.com</a>	Generic drugs ( <u>Formulary</u> generic drugs)	<i>Retail:</i> \$10 <u>copayment</u> /script (\$15 <u>copayment</u> /script if you do not participate in the wellness program). <i>Mail order:</i> \$20 <u>copayment</u> /script (\$30 <u>copayment</u> /script if you do not participate in the wellness program)	Not covered (limited exceptions for emergency prescriptions) No charge for ACA-required generic preventive drugs (such as contraceptives) (or brand drug if generic is not medically appropriate).	<ul style="list-style-type: none"> <li>• <u>Deductible</u> does not apply. <u>Cost sharing</u> counts toward the <u>out-of-pocket limit</u> for <u>prescription drugs</u> (not the medical limit).</li> <li>• Limited to a 30-day supply at retail and a 90-day supply for mail-order.</li> <li>• Mail Order is <b>required</b> for maintenance medications after the third fill at a retail pharmacy. After the 3rd refill at retail, you will be charged 2 <u>copayments</u>/fill.</li> <li>• No charge for ACA-required generic preventive care drugs (such as contraceptives) or brand name drugs if a generic is medically inappropriate.</li> <li>• Some prescription drugs are subject to <u>preauthorization</u> (to avoid non-payment), quantity limits or step therapy requirements.</li> <li>• Certain <u>preventive care</u> drugs are payable at no charge with a prescription.</li> </ul>
	Preferred brand drugs ( <u>Formulary</u> brand)	<i>Retail:</i> \$20 <u>copayment</u> /script (\$35 <u>copayment</u> /script if you do not participate in the wellness program). <i>Mail order:</i> \$40 <u>copayment</u> /script (\$70 <u>copayment</u> /script if you do not participate in the wellness program)		
	Non-preferred brand drugs (Non- <u>formulary</u> generic or Non- <u>formulary</u> brand drugs)	If <u>preauthorization</u> is obtained, paid as a formulary drug		
	<u>Specialty</u> drugs	Same <u>copayments</u> as retail <u>formulary</u> generic and retail <u>formulary</u> brand.		
			Not covered.	<ul style="list-style-type: none"> <li>• <u>Deductible</u> does not apply. <u>Cost sharing</u> counts toward the <u>out-of-pocket limit</u> for <u>prescription drugs</u> (not the medical limit).</li> <li>• <u>Specialty drugs</u> must be purchased through the Optum Specialty Pharmacy after the first fill at retail. Call (855) 798-5682 for information.</li> <li>• Limited to a 30-day supply.</li> </ul>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Non-Contract Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	100% <u>coinsurance</u> for charges above the Plan's maximum payment of \$350/day in the facility	<ul style="list-style-type: none"> <li>• <u>Preauthorization</u> by PHA required for all outpatient surgeries to avoid a 10% penalty.</li> <li>• The outpatient hospital facility fee is limited to a maximum allowed charge (MAC) of \$6,000 for an arthroscopy, \$2,000 for cataract surgery, \$1,500 for colonoscopy. These limits do not apply in an ambulatory surgical center.</li> <li>• Charges over <u>plan</u> limits do not count toward the <u>out-of-pocket limit</u>.</li> </ul>
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> by PHA required for all outpatient surgeries to avoid a 10% penalty.
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>coinsurance</u>	<u>Emergency medical condition</u> : 10% <u>coinsurance</u> (coinsurance maximum of \$6,000 per person per occurrence) Non-emergency: 40% <u>coinsurance</u>	<ul style="list-style-type: none"> <li>• Professional/physician charges may be billed separately.</li> <li>• If it is determined the patient does not have an Emergency Medical Condition, the \$6,000 coinsurance maximum will not apply.</li> </ul>
	<u>Emergency medical transportation</u>	Ground: \$50 <u>copayment</u> / trip. <u>Deductible</u> does not apply. Air: 20% <u>coinsurance</u>	Ground: \$50 <u>copayment</u> / trip. <u>Deductible</u> does not apply. Air: 20% <u>coinsurance</u>	Professional/physician charges may be billed separately. Covered when the medical condition of the patient requires paramedic support, or service to the nearest hospital that can provide appropriate treatment.
	<u>Urgent care</u>	\$20 <u>copayment</u> /visit (\$50 <u>copayment</u> /visit if you do not participate in the wellness program). <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	Professional/physician charges may be billed separately.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> by Anthem is required to avoid a 10% penalty. Facility fee plus required prostheses for total hip or total knee replacement performed in California subject to a maximum allowable charge (MAC) of \$30,000.
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> by Anthem is required to avoid a 10% penalty.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Non-Contract Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: \$20 <u>copayment</u> /visit (\$50 <u>copayment</u> /visit if you do not participate in the wellness program). <u>Deductible</u> does not apply. Other outpatient services: 10% <u>coinsurance</u>	40% <u>coinsurance</u>	Substance abuse services are not covered for dependents.
	Inpatient services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<ul style="list-style-type: none"> <li>Substance abuse services are not covered for dependents.</li> <li><u>Preauthorization</u> by Managed Health Network (MHN) is required to avoid a 10% penalty.</li> </ul>
If you are pregnant	Office visits	\$20 <u>copayment</u> /visit (\$50 <u>copayment</u> /visit if you do not participate in the wellness program). <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	<ul style="list-style-type: none"> <li><u>Cost sharing</u> does not apply for Contract <u>Provider preventive services</u>.</li> <li>Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).</li> </ul>
	Childbirth/delivery professional services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> by Anthem is required to avoid a 10% penalty only if hospital stay is longer than 48 hours for vaginal delivery or 96 hours for C-section.
	Childbirth/delivery facility services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	\$20 <u>copayment</u> /visit plus 10% <u>coinsurance</u>	40% <u>coinsurance</u>	The <u>deductible</u> does not apply to physician home visits.
	<u>Rehabilitation services</u>	Outpatient: \$20 <u>copayment</u> /visit (\$50 <u>copayment</u> if you do not participate in the wellness program). <u>Deductible</u> does not apply. Inpatient: 10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> by PHA required for all outpatient therapy to avoid a 10% penalty. Physical therapy and respiratory therapy are subject to an overall visit limit of 20 visits/calendar year (combined for all Contract and Non-Contract <u>providers</u> ). Speech and occupational therapy are limited to 20 visits/calendar year (combined for all Contract and Non-Contract <u>providers</u> ). If <u>preauthorization</u> is obtained, the Fund may allow <b>up to</b> 20 additional therapy visits.
	<u>Habilitation services</u>	\$20 <u>copayment</u> /visit (\$50 <u>copayment</u> /visit if you do not participate in the wellness program). <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	Facility: 55% <u>coinsurance</u> . Nursing care billed separately is paid as <u>Home health care</u>	Facility: 65% <u>coinsurance</u> . Nursing care billed separately is paid as <u>Home health care</u>	<u>Cost sharing</u> does not count toward the medical <u>out-of-pocket limit</u> . Limited to 55 days per calendar year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Contract Provider (You will pay the least)	Non-Contract Provider (You will pay the most)	
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> by PHA is required for DME over \$500 to avoid a 10% penalty.
	<u>Hospice services</u>	No charge, <u>deductible</u> does not apply.	No charge, <u>deductible</u> does not apply.	Covered for patients with less than 6-month life expectancy.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	If you elect vision coverage, it will be available under a separate vision <u>plan</u> .
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	If you elect dental coverage, it will be available under a separate dental <u>plan</u> .

### Excluded Services & Other Covered Services:

<b>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <u>excluded services</u>.)</b>		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult, child) (available under separate dental <u>plan</u>)</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (Adult, child) (available under separate vision <u>plan</u>).</li> <li>• Weight loss programs (except as required by the health reform law)</li> </ul>

<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)</b>		
<ul style="list-style-type: none"> <li>• Acupuncture (limited to 24 visits per year combined with chiropractic care for Contracted and Non-Contracted <u>providers</u>)</li> <li>• Bariatric surgery (<u>preauthorization</u> required; covered only at an Anthem Blue Distinction facility)</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care (limited to 24 visits per year combined with acupuncture)</li> <li>• Hearing aids (\$2,000/device/ear; every 3 years)</li> </ul>	<ul style="list-style-type: none"> <li>• Private duty nursing</li> <li>• Routine foot care (Orthotics limited to a \$200 max per calendar year. Coverage for contract <u>providers</u> only and only for the employee.)</li> </ul>

**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 Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](http://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 on how 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 Trust Fund Office at 1-800-527-4613. 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](http://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 1-800-527-4613.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-527-4613.

Chinese (中文): 如果需要中文的帮助, ☐☐☐☐☐☐☐ 1-800-527-4613.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-527-4613.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*



**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 \$250
- Specialist copayment \$50
- Hospital (facility) coinsurance 10%
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$270
Coinsurance	\$980
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Peg would pay is</b>	<b>\$1,520</b>

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

- The plan's overall deductible \$250
- Specialist copayment \$50
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$10
Copayments	\$1,410
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$230
<b>The total Joe would pay is</b>	<b>\$1,650</b>

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

- The plan's overall deductible \$250
- Specialist copayment \$50
- Hospital (facility) coinsurance 10%
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$550
Coinsurance	\$70
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$870</b>

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact the Trust Fund Office.

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