




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 or call 1-800-527-4613 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Contract <u>providers</u> : \$250/individual or \$750/family per calendar year Non-Contract <u>providers</u> : \$500/individual or \$1,500/family per calendar year. (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> .
Are there services covered before you meet your deductible?	Yes. Contract <u>providers</u> : <u>preventive care</u> , <u>prescription drugs</u> , hearing exams/aids and <u>hospice services</u> are covered before you meet your <u>deductible</u> . Non-Contract <u>providers</u> : <u>prescription drugs</u> , hearing exams/ aids, <u>hospice services</u> 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 https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Medical <u>plan</u> contract <u>providers</u> : \$2,000/individual, \$6,000/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.
What is not included in the out-of-pocket limit?	Medical plan: <u>deductible</u> , <u>premiums</u> , <u>balance-billing</u> charges, penalties for failure to obtain <u>preauthorization</u> , <u>skilled nursing</u> facility, charges from Non-Contract <u>providers</u> , 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 <u>plan</u> doesn't cover. Prescription Drugs: <u>deductible</u> , <u>premiums</u> , <u>balance-billing</u> charges, charges from <u>Non-Network</u> pharmacies, medical expenses, expenses for vision or dental care (if elected), and drugs this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.anthem.com or call 1-800-274-7767 for a list of medical Contract <u>providers</u> . See www.mhn.com or call 1-800-977-7962 for a list of Contract mental health and substance abuse <u>providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's 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 charge</u> and what your <u>plan</u> 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 <u>health care provider's office</u> or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
	<u>Specialist</u> visit			
	<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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> of radiology/x-ray by Pacific Health Alliance (PHA) is required for genetic testing to avoid a 10% penalty. Non-complex 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)	20% <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.

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 drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com	Generic drugs (Formulary generic drugs)	Retail: \$10 <u>copayment</u> /script. Mail order: \$20 <u>copayment</u> /script	Not covered (limited exceptions for emergency prescriptions)	<ul style="list-style-type: none"> • <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). • Limited to a 30-day supply at retail and a 90-day supply for mail-order. • Mail Order is required 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. • No charge for ACA-required generic preventive care drugs (such as contraceptives) or brand name drugs if a generic is medically inappropriate. • Some prescription drugs are subject to <u>preauthorization</u> (to avoid non-payment), quantity limits or step therapy requirements. • Certain over-the-counter (OTC) and <u>prescription drugs</u> are payable at no charge with a prescription.
	Preferred brand drugs (Formulary brand)	Retail: \$20 <u>copayment</u> /script. Mail order: \$40 <u>copayment</u> /script		
	Non-preferred brand drugs (Non-formulary generic or Non-formulary brand drugs)	If <u>preauthorization</u> is obtained, paid as a formulary drug		
	<u>Specialty drugs</u>	Same <u>copayments</u> as retail formulary generic and retail formulary brand drugs <u>copayments</u> .		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u> plus any amount above the <u>Plan's</u> maximum payment of \$350/day in the facility	<ul style="list-style-type: none"> • <u>Preauthorization</u> by PHA required for all outpatient surgeries to avoid a 10% penalty. • 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. • Charges over <u>plan</u> limits do not count toward the <u>out-of-pocket limit</u>.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> by PHA required for all outpatient surgeries 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 immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	<u>Emergency medical condition</u> : 20% <u>coinsurance</u> . Non-emergency: 40% <u>coinsurance</u>	Professional/physician charges may be billed separately. Non-Contract Provider <u>Emergency Medical Condition</u> participant coinsurance limited to \$6,000 per occurrence.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	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>coinsurance</u>	40% <u>coinsurance</u>	Professional/physician charges may be billed separately.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <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	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> by Anthem is required to avoid a 10% penalty.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Substance abuse treatment is covered for the Retiree only. You must pay 100% for substance abuse services of your dependents, even in-network.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> by MHN is required to avoid a 10% penalty. Substance abuse treatment is covered for the Retiree only. You must pay 100% for substance abuse services of your dependents, even in-network.
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<ul style="list-style-type: none"> • <u>Cost sharing</u> does not apply for Contract <u>Provider preventive services</u>. • Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% <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.

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)	
	Childbirth/delivery facility services	20% <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>coinsurance</u>	40% <u>coinsurance</u>	None.
	<u>Rehabilitation services</u>	20% <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 a combined overall visit limit of 20 visits/calendar year. Speech and occupational therapy are limited to 20 visits/calendar year combined. If <u>preauthorization</u> is obtained, the Fund may allow up to 20 additional physical, respiratory, speech, and/or occupational therapy visits if <u>Medically Necessary</u> .
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	55% <u>coinsurance</u>	65% <u>coinsurance</u>	
	<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.
If your child needs dental or eye care	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:

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> .)		
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult, child) (available under separate dental <u>plan</u>) 	<ul style="list-style-type: none"> • Infertility treatment • Long-term care • Non-emergency care when traveling outside U.S. • Private duty nursing 	<ul style="list-style-type: none"> • Routine eye care (Adult, child) (available under separate vision <u>plan</u>). • Substance abuse treatment for Dependents • Weight loss programs (except as required by the health reform law)

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

- Acupuncture (limited to 24 visits per year combined with chiropractic care)
- Bariatric surgery (preauthorization required; covered only at an Anthem Blue Distinction facility)
- Chiropractic care (limited to 24 visits per year combined with acupuncture)
- Hearing aids (\$2,000/device/ear; every 3 years)
- Routine foot care (Orthotics limited to a \$200 max per calendar year. Coverage for contract providers only and only for the employee.)

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. 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 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.

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 coinsurance 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:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$10
Coinsurance	1,750
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,070

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 coinsurance 20%
- 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:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$760
Coinsurance	\$130
<i>What isn't covered</i>	
Limits or exclusions	\$230
The total Joe would pay is	\$1,370

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

- The plan's overall deductible \$250
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- 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	\$1,900
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$10
Coinsurance	\$510
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$770

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