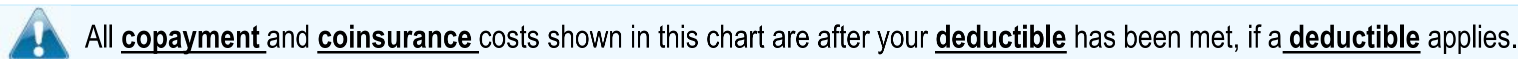
atThe Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. 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 providers: $250/individual or $500/family Non-Contract providers: $500/individual or $1,500/family	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, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Contract providers: office visits (and physician home visits), preventive care, prescription drugs, x-ray & lab (unless performed at hospital), chiro, acupuncture, outpatient rehabilitation services, outpatient habilitation services, outpatient mental health and substance abuse, urgent care, emergency ground ambulance, podiatry exams, hearing exams/aids, hospice services and the supplemental accident benefit are covered before you meet your deductible. Non-Contract providers: emergency ground ambulance, hearing exams/ aids, hospice care, and supplemental accident 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. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	Depending on the dental option that you elect, you may have a deductible under your dental plan. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before the dental plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Medical plan contract providers: $2,000/individual, $4,000/family. Prescription Drugs In-Network: $2,000/individual, $4,000/family.	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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	**Medical plan:** deductible, premiums, balance-billing charges, penalties for failure to obtain preauthorization, 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 prescription drugs, and health care this plan doesn't cover. **Prescription Drugs:** 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 out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com or call 1-800-274-7767 for a list of medical Contract providers. See www.mhn.com or call 1-800-977-7962 for a list of Contract mental health and substance abuse 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.	You can see the specialist you choose without a referral.



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: Contract Provider (You will pay the least)	What You Will Pay: Non-Contract Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment/visit ($50 copayment/visit if you do not participate in the wellness program). Deductible does not apply.	40% coinsurance	None.
	Specialist visit			
	Preventive care/screening/ Immunization	No charge. Deductible does not apply.	40% coinsurance	Age and frequency guidelines apply to covered preventive care. You may have to pay for services that aren't preventive care. Ask your provider if the services needed are preventive. Then check what your plan will pay for.

<table>
<tr><th rowspan="2">Common Medical Event</th><th rowspan="2">Services You May Need</th><th colspan="2">What You Will Pay</th><th rowspan="2">Limitations, Exceptions, & Other Important Information</th></tr>
<tr><th>Contract Provider
(You will pay the least)</th><th>Non-Contract Provider
(You will pay the most)</th></tr>
<tr><td rowspan="2">If you have a test</td><td>Diagnostic test (x-ray, blood work)</td><td>Hospital: 10% coinsurance.

Other Facility: $20 copayment/test ($50 copayment/test if you do not participate in the wellness program); deductible does not apply.</td><td>40% coinsurance</td><td>Preauthorization by Pacific Health Alliance (PHA) is required to avoid a 10% penalty. X-rays performed in your physician's office do not require preauthorization. Professional/physician charges may be billed separately.</td></tr>
<tr><td>Imaging (CT/PET scans, MRIs)</td><td>10% coinsurance</td><td>40% coinsurance</td><td>Preauthorization by PHA is required to avoid a 10% penalty. Professional/physician charges may be billed separately.</td></tr>
<tr><td rowspan="4">If you need drugs to treat your illness or condition
More information about prescription drug coverage is available at www.optumrx.com</td><td>Generic drugs (Formulary generic drugs)</td><td>Retail: $10 copayment/script ($15 copayment/script if you do not participate in the wellness program).
Mail order: $20 copayment/script ($30 copayment/script if you do not participate in the wellness program)</td><td rowspan="3">Not covered (limited exceptions for emergency prescriptions)</td><td rowspan="3">• Deductible does not apply. Cost sharing counts toward the out-of-pocket limit for prescription drugs (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 copayments/fill.
• No charge for FDA-approved generic contraceptives (or brand name contraceptives if a generic is medically inappropriate).
• Some prescription drugs are subject to preauthorization (to avoid non-payment), quantity limits or step therapy requirements.
• Certain over-the-counter (OTC) and prescription drugs are payable at no charge with a prescription.</td></tr>
<tr><td>Preferred brand drugs (Formulary brand)</td><td>Retail: $20 copayment/script ($35 copayment/script if you do not participate in the wellness program).
Mail order: $40 copayment/script ($70 copayment/script if you do not participate in the wellness program)</td></tr>
<tr><td>Non-preferred brand drugs (Non-formulary generic or Non-formulary brand drugs)</td><td>If preauthorization is obtained, paid as a formulary drug</td></tr>
<tr><td>Specialty drugs</td><td>Same copayments as retail formulary generic and retail formulary brand drugs copayments.</td><td>Not covered.</td><td>• Deductible does not apply. Cost sharing counts toward the out-of-pocket limit for prescription drugs (not the medical limit).
• Specialty drugs must be purchased through the Optum Specialty Pharmacy after the first fill at retail. Call (855) 798-5682 for information.
• Limited to a 30-day supply.</td></tr>
</table>

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% coinsurance	100% coinsurance for charges above the Plan's maximum payment of $350/day in the facility	• Preauthorization 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 plan limits do not count toward the out-of-pocket limit.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	Preauthorization by PHA required for all outpatient surgeries to avoid a 10% penalty.
If you need immediate medical attention	Emergency room care	10% coinsurance	Emergency medical condition: 10% coinsurance (coinsurance maximum of $6,000 per person per occurrence) Non-emergency: 40% coinsurance	Professional/physician charges may be billed separately.
	Emergency medical transportation	Ground: $50 copayment/ trip. Deductible does not apply. Air: 20% coinsurance	Ground: $50 copayment/ trip. Deductible does not apply. Air: 20% coinsurance after deductible	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.
	Urgent care	$20 copayment/visit ($50 copayment/visit if you do not participate in the wellness program). Deductible does not apply.	40% coinsurance	Professional/physician charges may be billed separately.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	Preauthorization 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.

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)	
	Physician/surgeon fees	10% coinsurance	40% coinsurance	Preauthorization by Anthem is required to avoid a 10% penalty.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: $20 copayment/visit ($50 copayment/visit if you do not participate in the wellness program). Deductible does not apply. Other outpatient services: 10% coinsurance	40% coinsurance	Substance abuse services are not covered for dependents.
	Inpatient services	10% coinsurance	40% coinsurance	• Substance abuse services are not covered for dependents. • Preauthorization by Managed Health Network (MHN) is required to avoid a 10% penalty.
If you are pregnant	Office visits	$20 copayment/visit ($50 copayment/visit if you do not participate in the wellness program). Deductible does not apply.	40% coinsurance	• Cost sharing does not apply for Contract Provider preventive services. • Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	10% coinsurance	40% coinsurance	Preauthorization 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% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	$20 copayment/visit plus 10% coinsurance	40% coinsurance	None.
	Rehabilitation services	Outpatient: $20 copayment/visit ($50 copayment if you do not participate in the wellness program). Deductible does not apply. Inpatient: 20% coinsurance	40% coinsurance	Preauthorization 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 preauthorization is obtained, the Fund may allow additional therapy visits after major surgery, stroke or a heart attack.
	Habilitation services	$20 copayment/visit ($50 copayment/visit if you do not participate in the wellness program). Deductible does not apply.	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay: Contract Provider (You will pay the least)	What You Will Pay: Non-Contract Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Skilled nursing care	Facility: 55% coinsurance. Nursing care billed separately is paid as Home health care	Facility: 65% coinsurance. Nursing care billed separately is paid as Home health care	Cost sharing does not count toward the medical out-of-pocket limit. Limited to 55 days per disability. Admission must occur after a 5-day (or longer) inpatient hospital stay, and must be admitted to the skilled nursing facility within 7 days of hospital discharge.
	Durable medical equipment	20% coinsurance	40% coinsurance	Preauthorization by PHA is required for DME over $500 to avoid a 10% penalty.
	Hospice services	No charge, deductible does not apply.	No charge, deductible 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 plan.
	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 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
- Dental care (Adult, child) (available under separate dental plan)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside U.S.
- Private-duty nursing
- Routine eye care (Adult, child) (available under separate vision plan).
- 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 20 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 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
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.

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，请拨打这个号码 1-800-527-4613.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo 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.

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.

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)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$140
Coinsurance	$1,030
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$1,430**

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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$60
Copayments	$2,020
Coinsurance	$0
What isn't covered	
Limits or exclusions	$450
The total Joe would pay is	**$2,530**

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)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$410
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$710**

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