**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, see www.norcalcementmasons.org or call 1-888-245-5005. 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 1-888-245-5005 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $250/person, $750/family per calendar year for Participating Providers. | Generally, you must pay all 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**, ACA Preventive Care, prescription drugs, mental health/substance abuse services, and a routine physical exam with a Participating Provider 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?** | **No**. | You don't have to meet **deductibles** for specific services. |
| **What is the out-of-pocket limit for this plan?** | ***In-Network Medical Providers:*** $3,000 person/$6,000 family per calendar year. ***In-Network Prescription Drugs:*** $1,200 person/$2,400 Family per calendar year. | The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have 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. |
| **What is not included in the out-of-pocket limit?** | **Medical Out-of-Pocket Limit** does not include: Premiums, balance-billing charges, Non-Participating claims; copays, deductible, and coinsurance, penalties for failure to obtain preauthorization, plan excluded services, outpatient prescription drugs and amounts over the Maximum Plan Allowance (MPA) for certain services. **Prescription Drug Out-of-Pocket Limit** does not include: Medical charges, premiums, balance billing charge, plan excluded services and Out-of-Network prescription drugs. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **Will you pay less if you use a network provider?** | **Yes**.<br>For a list of network providers contact;<br>**Medical**: **www.anthem.com/ca** or call 1-866-755-2680.<br>**Mental Health/Substance Abuse:**<br>**Liveandworkwell.com** or call 1-800-842-0209 | 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 | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating 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, Deductible does not apply. | $20 copay/visit **plus** 50% coinsurance **plus** any balance-billing. | None |
| | Specialist visit | 15% coinsurance | 50% coinsurance **plus** any balance-billing | Preauthorization from Anthem is required for certain specialty services in order to avoid a 20% penalty. |
| | Preventive care / screening / immunization | **Services mandated by Health Reform:**<br>No charge. Deductible does not apply.<br>**Other immunizations:**<br>15% coinsurance | $20 copay **plus** 50% coinsurance per office visit<br>**&**<br>50% coinsurance for other covered preventive care services (including immunizations not required by health reform) **plus** any balance-billing | 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.<br>**https://www.healthcare.gov/coverage/preventive-care-benefits/** |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 15% coinsurance | 50% coinsurance **plus** any balance-billing | X-rays provided by a chiropractor or associated with spinal manipulation services are limited to $300/ Calendar Year. |
| | Imaging (CT/PET scans, MRIs) | 15% coinsurance | 50% coinsurance **plus** any balance-billing | • Preauthorization by Anthem is required to avoid an **additional** 20% coinsurance for non-compliance. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.OptumRx.com | Generic drugs | $10 **Retail**<br>$20 **Mail Order** copay/prescription | You pay 100%.<br><br>Plan reimburses based on the contract rate for an In-Network Pharmacy less any copay. | • Deductible does not apply.<br>• 30-day supply **Retail**; 90-day supply **Mail Order**.<br>• **Double copay** Retail after 3rd fill.<br>• ACA preventive care drugs are not covered if purchased at a Non-Network pharmacy.<br>• No charge for FDA-approved generic contraceptives (or brand name if generic is medically inappropriate). |
| | Preferred brand drugs | $25 copay/prescription **Retail**<br>$50 copay/prescription **Mail Order** | | |
| | Non-preferred brand drugs | Not covered | Not covered | You pay 100% of the cost for non-preferred brand drugs, even if purchased at an In-Network Pharmacy. |
| | Specialty drugs | $25 copay/injectable meds. Oral meds same copays as above for generic or preferred brand mail order. | Not covered | **Deductible does not apply**. Must use contracting provider (BriovaRx) for all specialty drugs. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 15% coinsurance | You pay the excess of $500/day | • You pay all charges in excess of $500/day if you use a **non-PPO** ambulatory surgery center.<br>• For hospital-based outpatient surgery facilities, the maximum plan allowance for arthroscopy is $6,000; cataract is $2,000; colonoscopy is $1,500.<br>• **Preauthorization by Anthem is required** for arthroscopy, cataract & colonoscopy to avoid an additional 20% coinsurance for non-compliance. |
| | Physician/surgeon fees | 15% coinsurance | 50% coinsurance **plus** any balance-billing. | **Preauthorization by Anthem is required** for arthroscopy, cataract & colonoscopy to avoid an additional 20% penalty. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| **If you need immediate medical attention** | Emergency room care | $100 copay/visit **plus** 15% coinsurance | $100 copay/visit **plus** 15% coinsurance | • Copay waived if admitted to the hospital.<br>• Professional fees may be billed separately. |
| | Emergency medical transportation | 15% coinsurance | Air ambulance services (if covered when furnished by a Participating Provider): 15% coinsurance<br>Other: 20% coinsurance **plus** any balance-billing. | None. |
| | Urgent care | $20 copay/visit | $20 copay/visit **plus** 50% coinsurance **plus** any balance-billing. | This is for a non-hospital urgent care center.<br>Professional fees may be billed separately. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 15% coinsurance of the 1st $15,000<br>No cost for remainder of hospital stay | 50% coinsurance of the 1st $15,000 (20% coinsurance *if admission is due to an emergency or you live out-of-area)* **plus** any balance-billing. | • Preauthorization is required to avoid a 20% penalty.<br>• Routine hip or knee replacement surgery limited to *maximum plan allowance* of $30,000.<br>• Use designated Value Based hospital facilities for MPA listed surgeries if you are a California resident.<br>• No cost for remainder of hospital stay ***except*** for any balance-billing that a Non-Participating provider may charge you). |
| | Physician / surgeon fees | 15% coinsurance | 50% coinsurance **plus** any balance-billing. | None. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Benefit is covered at 100%.<br>Deductible does not apply. | $20 copay and 50% coinsurance/office visit<br>50% coinsurance for other outpatient services<br>**Plus** any balance-billing | Contact Optum BHS for a list of participating providers.<br>Non-Participating providers may balance bill you. |
| | Inpatient services | Benefit is covered at 100%.<br>Deductible does not apply. | 50% coinsurance (20% if emergency admission) of the 1st $15,000. No cost for remainder of hospital stay ***except*** for any balance-billing). | Preauthorization is required from Optum BHS to avoid a 20% penalty. |
| **If you are pregnant** | Office visits | Included in delivery and facility services | Included in delivery and facility services | • Cost sharing does not apply for preventive services.<br>• Prenatal care (other than ACA-required preventive screenings) is not covered for dependent children. |

* For more information about limitations and exceptions, see plan document at www.norcalcementmasons.org

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| | | | | • Depending on the type of services, a copay, coinsurance, or deductible may apply.<br>• Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth / delivery professional services | 15% coinsurance | 50% coinsurance **plus** any balance-billing | • Preauthorization by Anthem required for inpatient stays exceeding 24 hours for a vaginal delivery / 48 hours for a C-section to avoid a penalty of non-payment.<br>• Copay waived for participation in the "Future Moms" program.<br>• Delivery expenses are not covered for dependent children except for an Emergency Medical Condition.<br>• Deductible applies |
| | Childbirth / delivery facility services | $1,000 copay plus 15% coinsurance of the 1st $15,000. | $1,000 copay **plus** 50% coinsurance **plus** any balance-billing. | |
| **If you need help recovering or have other special health needs** | Home health care | 15% coinsurance | 50% coinsurance **plus** any balance-billing | Preauthorization by Anthem is required to avoid a penalty of non-payment. |
| | Rehabilitation services | 15% coinsurance | 50% coinsurance **plus** any balance-billing | • Inpatient rehabilitation services require preauthorization by Anthem to avoid a penalty of non-payment.<br>• Outpatient rehabilitation (physical/speech/occupational) services require preauthorization by Anthem to avoid a 20% penalty. |
| | Habilitation services | Not covered | Not Covered | You pay 100% of these services, even in-network. |
| | Skilled nursing care | 15% coinsurance | 50% coinsurance **plus** any balance-billing | Preauthorization by Anthem is required to avoid a 20% penalty. |
| | Durable medical equipment | 15% coinsurance | 50% coinsurance **plus** any balance-billing | Requires a physician's prescription. If you participate in the wellness program, charges of $500 or more require preauthorization by a Care Counselor in order to avoid a 20% penalty. |
| | Hospice services | 15% coinsurance | 50% coinsurance **plus** any balance-billing | Preauthorization by Anthem is required to avoid a penalty of non-payment. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | Not covered | May be covered under separate vision plan |
| | Children's glasses | Not covered | Not covered | |
| | Children's dental check-up | Not covered | Not covered | |

## 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 (may be covered under a separate dental plan)
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Non-preferred brand drugs
- Private-duty nursing
- Routine eye care (may be covered under a separate vision plan)
- Routine foot care
- Weight-loss programs (except as required by health reform)

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

- Acupuncture (if prescribed for the treatment of pain) 12 visits for non-trauma, injury or surgery. 24 visits for trauma, injury or surgery. (Need confinement set up)
- Bariatric surgery (when medically necessary)
- Chiropractic care ($40 per visit up to 40 visits per plan year)
- Hearing aids ($1,000/ear/device every 36 months)

**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 1-866-444-3272 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.

* For more information about limitations and exceptions, see plan document at www.norcalcementmasons.org

**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 Board of Trustees for the Cement Masons Health and Welfare Trust Fund for Northern California, 4160 Dublin Blvd., Suite 100, Dublin, CA 94568. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthcarereform.

**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 888-245-5005.

* For more information about limitations and exceptions, see plan document at www.norcalcementmasons.org

## 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 | $250 |
| Specialist coinsurance | 15% |
| Hospital (facility) coinsurance | 15% |
| Other coinsurance | 15% |

**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** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $250 |
| Copayments | $1.010 |
| Coinsurance | $1,640 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Peg would pay is** | **$2,920** |

### 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 | 15% |
| Hospital (facility) coinsurance | 15% |
| Other coinsurance | 15% |

**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** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $250 |
| Copayments | $950 |
| Coinsurance | $40 |
| *What isn't covered* | |
| Limits or exclusions | $160 |
| **The total Joe would pay is** | **$1,400** |

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

| | |
|---|---|
| The plan's overall deductible | $250 |
| Specialist coinsurance | 15% |
| Hospital (facility) *coinsurance* | 15% |
| Other coinsurance | 15% |

**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** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $250 |
| Copayments | $290 |
| Coinsurance | $340 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$880** |

Note: These numbers assume the patient does not participate in the plan's "Promise" Program. If you participate in the plan's "Promise" program, you may be able to reduce your costs. For more information about the "Promise" program, please contact the Trust Fund Office at 888-245-5005.

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