**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, visit www.dc16trustfund.org or call 1-800-922-9902. 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 1-800-922-9902 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | APPO providers: **$0**<br>Non-APPO providers: **$500**/individual, **$1,000**/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. Chiropractic services, mental health and chemical dependency services through Beat It!, outpatient prescription drugs, and emergency room facility charges. | 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?** | Yes. Depending on the dental option you choose, you may have a deductible for dental services under a separate 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 APPO providers: **$3,500**/individual, **$7,000**/family<br>Outpatient Prescription Drugs (in-network): **$3,100**/individual, **$6,200**/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. |
| **What is not included in the out-of-pocket limit?** | Medical APPO Out-of-Pocket Limit does not include: Premiums, balance-billing charges, charges exceeding the reference-based price, charges from Non-APPO providers (except emergency services for emergency medical condition), penalties for failure to obtain preauthorization, prescription drug costs, dental and vision expenses, and health care this plan doesn't cover. Prescription Drug Out-of-Pocket Limit does not include: Premiums, balance-billing charges, out-of-network prescription drugs, Non-formulary drugs (unless exception approved), medical, dental and vision expenses. | 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. See www.anthem.com/ca. For a list of Anthem Blue Card providers outside of California see www.bluecares.com or call 1-800-810-2583. For mental health and chemical dependency benefits, contact Beat It! at 1-800-828-3939. | You pay the least if you use a provider in the APPO network. You pay more if you use a provider in the PPO network that is not an APPO provider. 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. However, preauthorization from Care Counseling is required to receive the highest level of benefits. Please call Care Counseling at 1-800-999-1999 for more information. | 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 |
|---|---|---|---|---|---|
| | | APPO Provider (You will pay the least) | PPO Provider that is not an APPO Provider | Non-PPO 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 copayment/ visit | 50% coinsurance. | 50% coinsurance plus balance billing. | None. |
| | Specialist visit | $20 copayment/ visit (reimbursed if you call the Care Counseling program before the service is obtained). | 50% coinsurance. | 50% coinsurance plus balance billing. | None. |
| | Preventive care/screening/ immunization | No charge. | 50% coinsurance. | 50% coinsurance plus 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. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | $20 copayment/ procedure (See Specialist visit, above). | 50% coinsurance. | 50% coinsurance plus balance billing. | Lab services obtained in a provider's office but sent to a free-standing lab for processing require a separate lab copayment (unless preauthorization from Care Counseling Services is obtained). |
| | Imaging (CT/PET scans, MRIs) | $20 copayment/ visit (See Specialist visit, above). | 50% coinsurance. | 50% coinsurance plus balance billing. | None. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | APPO Provider (You will pay the least) | PPO Provider that is not an APPO Provider | Non-PPO 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.welldynerx.com or call 1-888-479-2000. | Formulary drugs | Retail (30-day supply): $4 copayment/fill Mail Order (90-day supply): $8 copayment/fill | You must pay 100% of the cost at the time of purchase, and submit a claim for reimbursement. The Plan will reimburse the cost of the drug if filled at an in-network pharmacy, less the applicable copayment. | | • Deductible does not apply. Your cost sharing counts toward the out-of-pocket limit for prescription drugs.<br>• If the cost of the drug is less than the copayment, you pay just the drug cost.<br>• No charge for ACA-required generic preventive care drugs (such as contraceptives) or brand name drugs if a generic is medically inappropriate.<br>• Your provider can request a formulary exception if you are not able to take a formulary drug. |
| | Non-Formulary drugs | Not covered | Not covered | Not covered | You pay 100% of these drugs, even in-network (unless an exception is approved by the PBM). |
| | Specialty drugs | $20 copayment/fill, plus 20% coinsurance. | Not covered | Not covered | Physician administered drugs and infusion drugs provided under a Home Health program require preauthorization to avoid nonpayment. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $20 copayment/visit (See Specialist visit, above). | Ambulatory Surgical Center: 25% coinsurance.<br>Outpatient Hospital: 50% coinsurance. | Ambulatory Surgical Center: 25% coinsurance plus balance billing.<br>Outpatient Hospital: 50% coinsurance plus balance billing. | • Preauthorization of elective surgery at an ambulatory surgery center is is required to avoid a 25% penalty.<br>• Arthroscopies, cataract surgery, and colonoscopies performed in an outpatient hospital setting are subject to a maximum allowed charge for the facility fee of $6,000 per arthroscopy, $2,000 per cataract surgery, and $1,500 per colonoscopy. (These limits do not apply to surgery in an ambulatory surgery center.)<br>• Non-APPO facility fee for arthroscopy, cataract surgery, colonoscopy are subject to a maximum payment of $350. You are responsible for any amount over $350.<br>• Charges over these limits do not count toward the out-of-pocket limit. |
| | Physician/ surgeon fees | $20 copayment/visit (See Specialist visit, above). | 50% coinsurance | 50% coinsurance | |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | APPO Provider (You will pay the least) | PPO Provider that is not an APPO Provider | Non-PPO Provider (You will pay the most) | |
| **If you need immediate medical attention** | Emergency room care | $100 copayment/visit. | $100 copayment/ visit. Deductible does not apply. | $100 copayment/ visit, ~~plus balance billing~~. Deductible does not apply. | Copayment waived if transported to the hospital by professional ambulance or if you are admitted to the hospital directly from the emergency room. Physician/professional services may be billed separately. |
| | Emergency medical transportation | $100 copayment/trip. | $100 copayment/ trip. | $100 copayment/ trip. | Covered only where patient's medical condition requires paramedic support, and to the first hospital where treatment is given. Physician/professional services may be billed separately. |
| | Urgent care | $20 copayment/visit (See Specialist visit, above). | 50% coinsurance. | 50% coinsurance plus balance billing. | Physician/professional services may be billed separately. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No charge. | 50% coinsurance (no charge if condition is life threatening and you are admitted through the emergency room). | 50% coinsurance (no charge except balance billing if condition is life threatening and you are admitted through the emergency room until medically safe to move). | • Non-emergency admission requires preauthorization from Anthem to avoid a 25% penalty.<br>• Total hip or total knee replacement surgeries performed within the state of California are subject to a maximum facility fee allowed charge of $35,000 per surgery.<br>• Charges over plan limits do not count toward the out-of-pocket limit.<br>• Semi-private room covered. |
| | Physician/ surgeon fees | No charge. | 50% coinsurance. | 50% coinsurance plus balance billing. | None. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | APPO Provider (You will pay the least) | PPO Provider that is not an APPO Provider | Non-PPO Provider (You will pay the most) | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | No charge. | **Anthem:** 50% coinsurance. **Beat It!:** No charge. Deductible does not apply. | **Anthem:** 50% coinsurance plus balance billing. **Beat It!:** 50% coinsurance. Deductible does not apply. | Deductible does not apply to Beat It!. |
| | Inpatient services | No charge. | **Anthem:** 50% coinsurance (See hospital stay facility fee row, above). **Beat It!:** No charge (See hospital stay facility fee row, above). Deductible does not apply. | 50% coinsurance (See hospital stay facility fee row, above). | Non-emergency admission requires preauthorization from Anthem or Beat It!. Deductible does not apply to Beat It!. |
| **If you are pregnant** | Office visits | $20 copayment/visit (See Specialist visit, above). | 50% coinsurance. | 50% coinsurance plus balance billing. | • Cost sharing does not apply for preventive services.<br>• Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). |
| | Childbirth/delivery professional services | No charge. | 50% coinsurance. | 50% coinsurance plus balance billing. | None. |
| | Childbirth/delivery facility services | No charge. | 50% coinsurance (See hospital stay facility fee row, above). | 50% coinsurance (See hospital stay facility fee row, above). | Semi-private room covered. Hospital stay of more than 48 hours for vaginal delivery or 96 hours for C-section requires preauthorization from Anthem to avoid a 25% penalty. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | APPO Provider (You will pay the least) | PPO Provider that is not an APPO Provider | Non-PPO Provider (You will pay the most) | |
| **If you need help recovering or have other special health needs** | Home health care | $10 copayment/visit. | 50% coinsurance. | 50% coinsurance plus balance billing. | Limited to 100 visits per calendar year. |
| | Rehabilitation services | Outpatient: $20 copayment/provider/ visit (See Specialist visit, above).<br>Inpatient: No charge | 50% coinsurance. | 50% coinsurance plus balance billing. | Inpatient admission requires preauthorization from Anthem to avoid a 25% penalty.<br>Outpatient rehabilitation services in excess of 25 visits in the calendar year require preauthorization from the Care Counseling Services to avoid nonpayment. |
| | Habilitation services | Not covered | Not covered | Not covered | You pay 100% of these services, even in-network. |
| | Skilled nursing care | No charge. | 50% coinsurance (See hospital stay facility fee row, above). | 50% coinsurance (See hospital stay facility fee row, above). | Inpatient admission requires preauthorization from Anthem to avoid a 25% penalty.<br>Limited to 100 days per calendar year. |
| | Durable medical equipment | No charge. | 50% coinsurance. | 50% coinsurance plus balance billing. | Rental covered up to purchase price. |
| | Hospice services | No charge. | 50% coinsurance. | 50% coinsurance plus balance billing. | Covered if terminally ill. |
| **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 through VSP. |
| | 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 through Delta Dental, DeltaCare USA, or UHC. |

## 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 and Child) (available under separate dental plan)
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside of the U.S.
- Non-formulary drugs (unless an exception is approved)
- Private-duty nursing
- Routine eye care (Adult and Child) (available under separate vision plan)
- Weight loss programs (except preventive services required under Health Reform)

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Acupuncture (up to 25 visits/year)<br>• Bariatric Surgery (preauthorization is required)<br>• Chiropractic care (up to 25 visits/year) | • Hearing aids (limited to $1,500/device every 48 months) | • Routine foot care (for insulin dependent diabetics) |

**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 1-800-922-9902. 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 1-800-922-9902.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-922-9902.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-922-9902.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-922-9902.

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

## 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**
- **Specialist copayment** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other copayment (Formulary Rx)** **$4**

**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 | $0 |
| Copayments | $20 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Peg would pay is** | **$40** |

### 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** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other copayment (Formulary Rx)** **$4**

**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 | $0 |
| Copayments | $320 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$320** |

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other copayment (ER)** **$100**

**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 | $0 |
| Copayments | $280 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$280** |

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