



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?	PPO and Non-PPO <u>providers</u> : \$300/individual, \$600/family	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. PPO ACA required <u>preventive care</u> , hearing aids, hospice care, chiropractic services, mental health and chemical dependency services through Beat It!, outpatient <u>prescription drugs</u> , ambulance, and emergency room facility charges.	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?	Yes. Depending on the dental option you choose, you may have a <u>deductible</u> for dental services under a separate <u>plan</u> . There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before the dental <u>plan</u> begins to pay for these services.
What is the out-of-pocket limit for this plan?	Medical <u>plan</u> PPO <u>providers</u> : \$3,500/individual, \$7,000/family Outpatient <u>Prescription Drugs</u> (in-network): \$3,100/individual, \$6,200/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 PPO <u>Out-of-Pocket Limit</u> does not include: <u>Premiums</u> , <u>balance-billing</u> charges, charges exceeding the reference-based price, charges in excess of benefit maximums, charges from Non-PPO <u>providers</u> (except <u>emergency services</u> for <u>emergency medical condition</u>), penalties for failure to obtain <u>preauthorization</u> , <u>prescription drug</u> costs, dental and vision expenses, and health care this <u>plan</u> doesn't cover. <u>Prescription Drug Out-of-Pocket Limit</u> does not include: <u>Premiums</u> , <u>balance-billing</u> charges, <u>out-of-network prescription drugs</u> , Non-formulary drugs (unless exception approved), medical, dental and vision expenses.	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/ca for a list of PPO providers. 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. For EAP benefit, contact Spring Health at 1-855-629-0554.	This plan 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. However, <u>preauthorization</u> 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 <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
		PPO Provider (You will pay the least)	Non-PPO 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>copayment</u> /visit	50% <u>coinsurance</u> plus <u>balance billing</u> .	None.
	<u>Specialist</u> visit	\$20 <u>copayment</u> /visit (reimbursed if you call the Care Counseling program before service is obtained). <u>Deductible</u> does not apply.	50% <u>coinsurance</u> plus <u>balance billing</u> .	None.
	<u>Preventive care</u> / <u>screening</u> / <u>immunization</u>	No charge, <u>deductible</u> does not apply.	50% <u>coinsurance</u> plus <u>balance billing</u> .	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. 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>copayment</u> /procedure (reimbursed if you call the Care Counseling program before the service is obtained).	50% <u>coinsurance</u> plus <u>balance billing</u> .	Lab services obtained in a <u>provider's office</u> but sent to a free-standing lab for processing require a separate lab <u>copayment</u> (unless <u>preauthorization</u> from Care Counseling Services is obtained).
	Imaging (CT/PET scans, MRIs)	\$20 <u>copayment</u> /provider/visit (reimbursed if you call the Care Counseling program before the service is obtained).	50% <u>coinsurance</u> plus <u>balance billing</u> .	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at www.carelonrx.com or call 1-833-923-0115</p>	<u>Formulary</u> drugs	<p>Retail (30-day supply): \$4 <u>copayment/fill</u></p> <p>Mail Order (90-day supply): \$8 <u>copayment/fill</u></p>	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 <u>in-network</u> pharmacy, less the applicable <u>copayment</u> .	<ul style="list-style-type: none"> • <u>Deductible</u> does not apply. Your <u>cost sharing</u> counts toward the <u>out-of-pocket limit</u> for <u>prescription drugs</u>. • If the cost of the drug is less than the <u>copayment</u>, you pay just the drug cost. • No charge for ACA-required generic <u>preventive care</u> drugs (such as contraceptives) or brand name drugs if a generic is medically inappropriate. • Your <u>provider</u> can request a formulary exception if you are not able to take a <u>formulary</u> drug.
	Non- <u>Formulary</u> drugs	Not covered	Not covered	You pay 100% of these drugs, even <u>in-network</u> (unless an exception is approved by the PBM).
	<u>Specialty</u> drugs	\$20 <u>copayment/fill</u> , plus 20% <u>coinsurance</u> .	Not covered	Physician administered drugs and infusion drugs provided under a Home Health program require <u>preauthorization</u> to avoid nonpayment.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$20 <u>copayment/visit</u> (reimbursed if you call the Care Counseling program before the service is obtained).	<p>Ambulatory Surgical Center: 25% <u>coinsurance</u> plus <u>balance billing</u>.</p> <p>Outpatient Hospital: 50% <u>coinsurance</u> plus <u>balance billing</u>.</p>	<ul style="list-style-type: none"> • <u>Preauthorization</u> of elective surgery at an ambulatory surgery center is required to avoid a 25% penalty. • 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.) • Non-PPO facility fee for arthroscopy, cataract surgery, and colonoscopy are subject to a maximum payment of \$350. • Charges over these limits do not count toward the <u>out-of-pocket limit</u>.
If you have outpatient surgery	Physician/surgeon fees	\$20 <u>copayment/visit</u> (reimbursed if you call the Care Counseling	50% <u>coinsurance</u> plus <u>balance billing</u> .	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	program before service is obtained).		
	Emergency medical transportation	\$100 <u>copayment</u> /visit. <u>Deductible</u> does not apply.	\$100 <u>copayment</u> / visit. <u>Deductible</u> does not apply.	<u>Copayment</u> 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.
	Urgent care	\$100 <u>copayment</u> /trip. <u>Deductible</u> does not apply.	\$100 <u>copayment</u> / trip plus <u>balance billing</u> . <u>Deductible</u> does not apply.	<ul style="list-style-type: none"> 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. You will not be Balance Billed for covered air ambulance services.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u> (no charge if condition is life threatening and you are admitted through the emergency room until medically safe to move).	No charge if condition is life threatening and you are admitted through the emergency room until medically safe to move. If condition is not life threatening: 50% <u>coinsurance</u> plus <u>balance billing</u> .	<ul style="list-style-type: none"> Non-emergency admission requires <u>preauthorization</u> from Anthem to avoid a 25% penalty. 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. Charges over <u>plan</u> limits do not count toward the <u>out-of-pocket limit</u>. Semi-private room covered.
	Physician/surgeon fees	No charge.	50% <u>coinsurance</u> plus <u>balance billing</u> .	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	<p>Anthem: Office visits: No charge, subject to <u>deductible</u>. All other: No charge, subject to <u>deductible</u>. Beat It!: No charge, <u>deductible</u> does not apply. Spring Health EAP: No charge, <u>deductible</u> does not apply.</p>	Subject to <u>deductible</u> , 50% <u>coinsurance</u> plus <u>balance billing</u> .	Deductible does not apply to Spring Health EAP 10 free sessions per year.
	Inpatient services	<p>Anthem: subject to <u>deductible</u>, 20% <u>coinsurance</u> (no charge if condition is life threatening and you are admitted through the emergency room until medically safe to move). Beat It!: 20% <u>coinsurance</u> (no charge if condition is life threatening and you are admitted through the emergency room until medically safe to move). <u>Deductible</u> does not apply.</p>	Subject to <u>deductible</u> , 50% <u>coinsurance</u> (no charge except <u>balance billing</u> if condition is life threatening and you are admitted through the emergency room until medically safe to move).	Non-emergency admission requires <u>preauthorization</u> from Anthem or Beat It!.
If you are pregnant	Office visits	\$20 <u>copayment</u> /visit (reimbursed if you call the Care Counseling program before the service is obtained). <u>Deductible</u> does not apply.	50% <u>coinsurance</u> plus <u>balance billing</u> .	<ul style="list-style-type: none"> Cost sharing does not apply for <u>preventive services</u>. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge.	50% <u>coinsurance</u> plus <u>balance billing</u> .	None.
	Childbirth/delivery facility services	20% <u>coinsurance</u> (no charge if condition is life threatening and you are admitted through the emergency room until medically safe to move).	50% <u>coinsurance</u> (no charge except <u>balance billing</u> if condition is life threatening and you are admitted through the emergency room until medically safe to move).	Semi-private room covered. Hospital stay of more than 48 hours for vaginal delivery or 96 hours for C-section requires <u>preauthorization</u> from Anthem to avoid a 25% penalty.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	\$10 <u>copayment</u> /visit.	50% <u>coinsurance</u> plus <u>balance billing</u> .	Limited to 100 visits per calendar year.
	<u>Rehabilitation services</u>	Outpatient: \$20 <u>copayment</u> /provider/visit (reimbursed if you call the Care Counseling program before the service is obtained). Inpatient: 20% <u>coinsurance</u>	50% <u>coinsurance</u> plus <u>balance billing</u> .	Inpatient admission requires <u>preauthorization</u> from Anthem to avoid a 25% penalty. Outpatient <u>rehabilitation services</u> in excess of 25 visits in the calendar year require <u>preauthorization</u> from the Care Counseling Services to avoid nonpayment.
	<u>Habilitation services</u>	Outpatient: \$20 <u>copayment</u> /provider/visit (reimbursed if you call the Care Counseling program before the service is obtained). Inpatient: 20% <u>coinsurance</u>	50% <u>coinsurance</u> plus <u>balance billing</u> .	Speech therapy for mental health diagnosis is covered.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u> (no charge if condition is life threatening and you are admitted through the emergency room until medically safe to move).	50% <u>coinsurance</u> (no charge except <u>balance billing</u> if condition is life threatening and you are admitted through the emergency room until medically safe to move).	Inpatient admission requires <u>preauthorization</u> from Anthem to avoid a 25% penalty. Limited to 100 days per calendar year.
	<u>Durable medical equipment</u>	No charge.	50% <u>coinsurance</u> plus <u>balance billing</u> .	Rental covered up to purchase price.
	<u>Hospice services</u>	No charge. <u>Deductible</u> does not apply.	50% <u>coinsurance</u> plus <u>balance billing</u> . <u>Deductible</u> does not apply.	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 <u>vision plan</u> 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 <u>dental plan</u> 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 (except speech therapy for mental health diagnosis)
- 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)
- Bariatric Surgery (preauthorization is required)
- 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, kwijjigo 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 <u>deductible</u>	\$1,000
Specialist <u>copayment</u>	\$0
Hospital (facility) <u>coinsurance</u>	0%
Other <u>copayment</u> (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	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$20
<u>Coinsurance</u>	\$1,410
What isn't covered	
Limits or exclusions	\$20
The total Peg would pay is	\$1,750

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall <u>deductible</u>	\$1,000
Specialist <u>copayment</u>	\$0
Hospital (facility) <u>coinsurance</u>	0%
Other <u>copayment</u> (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	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$600

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall <u>deductible</u>	\$1,000
Specialist <u>copayment</u>	\$0
Hospital (facility) <u>coinsurance</u>	0%
Other <u>copayment</u> (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	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$260
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$560

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