




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 <u>deductible</u>?	\$1,000 person/\$3,000 family for Participating Providers (or \$300/person/\$900/family for Participating Providers if enrolled in the Promise Program).	Generally, you must pay all the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual deductible 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 <u>deductible</u>?	Yes, ACA <u>Preventive Care</u> and a routine physical exam with a Participating <u>Provider</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 <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	Medical Participating Providers: \$3,000 person/\$6,000 family. In-Network <u>Prescription Drugs</u>: \$1,000 person/\$3,000 Family.	The <u>out-of-pocket</u> limit 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 <u>out-of-pocket limit</u>?	Medical <u>Out-of-Pocket Limit</u> does not include: <u>Premiums</u> , <u>balance-billing</u> charges, health care this plan doesn't cover, copays, <u>deductible</u> , <u>coinsurance</u> on non-Participating claims, penalties for failure to obtain preauthorization, outpatient <u>prescription drugs</u> and amounts over the Maximum Plan Allowance (MPA) for certain services. <u>Prescription Drug Out-of-Pocket Limit</u> does not include: Medical charges, <u>premiums</u> , <u>balance billing</u> charge, healthcare this plan doesn't cover and Out-of-Network <u>prescription drugs</u> .	Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See: www.anthem.com/ca or call 1-866-755-2680.	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	\$20 copay /visit plus 50% coinsurance plus any balance-billing that a Non-Participating provider may charge you.	None.
	Specialist visit	20% coinsurance	50% coinsurance plus any balance-billing that a Non-Participating provider may charge you.	If you participate in the wellness program, you must receive Preauthorization from PHA for certain specialty services in order to avoid a 20% penalty. See page 57 of your SPD/Plan Document for details.
	Preventive care/screening/immunization	Services mandated by Health Reform: No charge. Deductible does not apply. Other immunizations: 20% coinsurance	\$20 copay plus 50% coinsurance per office visit & 50% coinsurance for other covered preventive care services (including immunizations not required by health reform) plus any balance-billing that a Non-Participating provider may charge you.	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.

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)	20% <u>coinsurance</u>	50% <u>coinsurance</u> plus any <u>balance-billing</u> that a Non-Participating provider may charge you.	None.	
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% <u>coinsurance</u> plus any <u>balance-billing</u> that a Non-Participating provider may charge you.	If you participate in the wellness program, <u>Preauthorization</u> by a Care Counselor is required to avoid an additional 20% <u>coinsurance</u> for non-compliance. X-rays associated with spinal manipulation services limited to \$300/Plan Year.	
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 <u>copay</u> /prescription Retail or \$20 <u>copay</u> /prescription Mail Order	You pay 100%. <u>Plan</u> reimburses based on the contract rate for an In-Network Pharmacy less any copay.	<ul style="list-style-type: none"> • Deductible does not apply. • 30-day supply Retail; 90-day supply Mail Order. • Double <u>copay</u> Retail after 3rd fill. • ACA <u>preventive care</u> drugs are not covered if purchased at a Non-Network pharmacy. • No charge for FDA-approved generic contraceptives (or brand name if generic is medically inappropriate). 	
	Preferred brand drugs	\$25 <u>copay</u> /prescription Retail or \$50 <u>copay</u> /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 <u>copay</u> /injectable meds. Oral meds same as above for generic or preferred brand	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)	20% <u>coinsurance</u>	You pay the excess of \$500/day	<ul style="list-style-type: none"> • You pay all charges in excess \$500/day if you use a non-PPO ambulatory surgery center. • For hospital based outpatient surgery facilities, the <u>maximum plan allowance</u> for arthroscopy is \$6,000; cataract is \$2,000; colonoscopy is \$1,500. • If you participate in the wellness program, <u>Preauthorization</u> by a Care Counselor is required for arthroscopy, cataract & colonoscopy to avoid an additional 20% <u>coinsurance</u> for non-compliance. 	

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)	
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u> plus any <u>balance-billing</u> that a Non-Participating provider may charge you.	If you participate in the wellness program, <u>Preauthorization</u> by a Care Counselor is required for arthroscopy, cataract & colonoscopy to avoid an additional 20% penalty.
If you need immediate medical attention	Emergency room care	\$100 <u>copay</u> /visit plus 20% <u>coinsurance</u>	\$100 <u>copay</u> /visit plus 20% <u>coinsurance</u> plus any <u>balance-billing</u> that a Non-Participating provider may charge you.	<u>Copay</u> waived if admitted to the hospital. Professional fees may be billed separately.
	Emergency medical transportation	20% <u>coinsurance</u>	20% <u>coinsurance</u> plus any <u>balance-billing</u> that a Non-Participating provider may charge you.	None.
	Urgent care	\$20 <u>copay</u> /visit	\$20 <u>copay</u> /visit plus 50% <u>coinsurance</u> plus any <u>balance-billing</u> that a Non-Participating provider may charge you.	This is for a non-hospital urgent care center. Professional fees may be billed separately.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u> of the 1st \$15,000. No cost for remainder of hospital stay	50% (20% if admission is due to an emergency or live out-of-area) of 1st \$15,000. No cost for remainder of hospital stay (except for any <u>balance-billing</u> that a Non-Participating provider may charge you).	<u>Preauthorization</u> by Anthem is required to avoid a 20% penalty. Routine hip or knee replacement surgery limited to maximum <u>plan</u> allowance of \$30,000. Use designated hospital facilities for hip or knee replacement surgery.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u> plus any <u>balance-billing</u> that a Non-Participating provider may charge you.	None.

* 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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <u>copay</u> /office visit and 20% <u>coinsurance</u> for other outpatient services	\$20 <u>copay</u> plus 50% <u>coinsurance</u> /office visit and 50% <u>coinsurance</u> for other outpatient services plus any <u>balance-billing</u> that a Non-Participating provider may charge you.	None.
	Inpatient services	20% <u>coinsurance</u> of the 1st \$15,000. No cost for remainder of hospital stay	50% (20% if emergency admission) <u>coinsurance</u> of 1st \$15,000. No cost for remainder of hospital stay (except any <u>balance-billing</u> that a Non-Participating provider may charge you).	<u>Preauthorization</u> by Anthem is required to avoid a 20% penalty.
If you are pregnant	Office visits	Included in delivery and facility services	Included in delivery and facility services	<ul style="list-style-type: none"> • <u>Cost sharing</u> does not apply for preventive services. • Prenatal care (other than ACA-required preventive screenings) is not covered for dependent children. • Depending on the type of services, a copay, <u>coinsurance</u>, or <u>deductible</u> may apply. • Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	\$1,000 <u>copay</u> plus 10% <u>coinsurance</u> of first \$15,000, then 20% <u>coinsurance</u>	\$1,000 <u>copay</u> plus 50% <u>coinsurance</u> plus any <u>balance-billing</u> that a Non-Participating provider may charge you.	<ul style="list-style-type: none"> • <u>Preauthorization</u> by Anthem required for inpatient stays exceeding 24 hours for a vaginal delivery/48 hours for a C-section to avoid a 20% penalty. • Copay waived for participation in the “Future Moms” program. • Delivery expenses are not covered for dependent children.
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	20% <u>coinsurance</u>	50% <u>coinsurance</u> plus any <u>balance-billing</u> that a Non-Participating provider may charge you.	
	Rehabilitation services	20% <u>coinsurance</u>	50% <u>coinsurance</u> plus any <u>balance-billing</u> that a Non-Participating provider may charge you.	Inpatient <u>rehabilitation services</u> require <u>preauthorization</u> by Anthem to avoid a 20% penalty.
	Habilitation services	Not covered	Not Covered	You pay 100% of these services, even in-network.

* 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)	
	Skilled nursing care	20% <u>coinsurance</u>	50% <u>coinsurance</u> plus any <u>balance-billing</u> that a Non-Participating provider may charge you.	None.
	Durable medical equipment	20% <u>coinsurance</u>	50% <u>coinsurance</u> plus any <u>balance-billing</u> that a Non-Participating provider may charge you.	Requires a physician's prescription. If you participate in the wellness program, charges of \$500 or more require <u>preauthorization</u> by a Care Counselor in order to avoid a 20% penalty.
	Hospice services	20% <u>coinsurance</u>	50% <u>coinsurance</u> plus any <u>balance-billing</u> that a Non-Participating provider may charge you.	<u>Preauthorization</u> by Anthem is required to avoid a penalty of non-payment.
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	May be covered under separate vision plan
	Children's dental check-up	Not covered	Not covered	May be covered under separate vision 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.)

<ul style="list-style-type: none"> • Cosmetic Surgery • Dental care (may be covered under a separate dental plan) • Habilitation services • Infertility treatment • Long-term care 	<ul style="list-style-type: none"> • 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) 	<ul style="list-style-type: none"> • Routine foot care • Weight-loss programs (except as required by health reform)
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

<ul style="list-style-type: none"> • Acupuncture (if prescribed for the treatment of pain) 	<ul style="list-style-type: none"> • Bariatric surgery (when medically necessary) • Chiropractic care (\$40 per visit up to 40 visits per plan year) 	<ul style="list-style-type: none"> • Hearing aids (\$1,000/ear/device every 36 months)
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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.

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 Board of Trustees for the Cement Masons Health and Welfare Trust Fund for Northern California, 1600 Harbor Bay Parkway, Suite 200, Alameda, CA 94502. 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

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 888-245-5005.

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	\$1,000
■ Specialist (coinsurance)	20%
■ Hospital (facility) (coinsurance)	20%
■ Other	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	\$12,731
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$0
Coinsurance	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,060

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$1,000
■ Specialist (coinsurance)	20%
■ Hospital (facility) (coinsurance)	20%
■ Other	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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$635
Coinsurance	\$585
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$2,275

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,000
■ Specialist (coinsurance)	20%
■ Hospital (facility) (coinsurance)]	20%
■ Other	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	\$1,925
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$0
Coinsurance	\$385
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,385

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.