



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> ?	\$250/person, \$750/family per calendar year for Participating Providers.	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 <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 <u>deductible</u> ?	Yes , ACA <u>Preventive Care</u> , <u>prescription drugs</u> , mental health/substance abuse services, 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> ?	<u>In-Network Medical Providers</u> : \$3,000 person/\$6,000 family per calendar year. <u>In-Network Prescription Drugs</u> : \$1,200 person/\$2,400 Family per calendar year.	The <u>out-of-pocket</u> limit is the most you could pay in a year for covered services. If you have 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> ?	<u>Medical Out-of-Pocket Limit</u> does not include: <u>Premiums</u> , <u>balance-billing</u> charges, <u>Non-Participating claims</u> , <u>copays</u> , <u>deductible</u> , and <u>coinsurance</u> , penalties for failure to obtain <u>preauthorization</u> , <u>plan excluded services</u> , outpatient <u>prescription drugs</u> and amounts over the Maximum <u>Plan Allowance</u> (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, <u>plan excluded services</u> and Out-of- <u>Network</u> <u>prescription drugs</u> .	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 network provider ?	Yes. For a list of network providers contact; Medical: www.anthem.com/ca or call 1-866-755-2680. Mental Health/Substance Abuse: 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 <u>copay</u> /visit, <u>Deductible</u> does not apply.	\$20 <u>copay</u> /visit plus 50% <u>coinsurance</u> plus any <u>balance-billing</u> .	None
	<u>Specialist</u> visit	15% <u>coinsurance</u>	50% <u>coinsurance</u> plus any <u>balance-billing</u>	<u>Preauthorization</u> from Anthem is required for certain specialty services in order to avoid a 20% penalty.
	<u>Preventive care</u> / <u>screening</u> / immunization	Services mandated by Health Reform: <u>No charge</u> . <u>Deductible</u> does not apply. Other immunizations: 15% <u>coinsurance</u>	\$20 <u>copay</u> plus 50% <u>coinsurance</u> per office visit & 50% <u>coinsurance</u> for other covered <u>preventive care</u> services (including immunizations not required by health reform) plus any <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 plan will pay for. 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	<u>Diagnostic test</u> (x-ray, blood work)	15% <u>coinsurance</u>	50% <u>coinsurance</u> plus any <u>balance-billing</u>	X-rays provided by a chiropractor or associated with spinal manipulation services are limited to \$300/Calendar Year.
	Imaging (CT/PET scans, MRIs)	15% <u>coinsurance</u>	50% <u>coinsurance</u> plus any <u>balance-billing</u>	<ul style="list-style-type: none"> • <u>Preauthorization</u> by Anthem is required to avoid an additional 20% <u>coinsurance</u> for non-compliance.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.OptumRx.com	Generic drugs	\$10 Retail \$20 Mail Order <u>copay/prescription</u>	You pay 100%.	<ul style="list-style-type: none"> • <u>Deductible</u> does not apply. • 30-day supply Retail; 90-day supply Mail Order. • Double copay Retail after 3rd fill. • ACA <u>preventive care</u> drugs are not covered if purchased at a Non-<u>Network</u> pharmacy. • No charge for FDA-approved generic contraceptives (or brand name if generic is medically inappropriate).
	Preferred brand drugs	\$25 <u>copay/prescription</u> Retail \$50 <u>copay/prescription</u> 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- <u>Network</u> Pharmacy.
	<u>Specialty drugs</u>	\$25 <u>copay/injectable</u> meds. Oral meds same <u>copays</u> as above for generic or preferred brand mail order.	Not covered	<u>Deductible</u> does not apply. Must use contracting <u>provider</u> (BriovaRx) for all <u>specialty drugs</u> .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% <u>coinsurance</u>	You pay the excess of \$500/day	<ul style="list-style-type: none"> • You pay all charges in excess of \$500/day if you use a non-PPO ambulatory surgery center. • For hospital-based outpatient surgery facilities, the maximum <u>plan</u> allowance for arthroscopy is \$6,000; cataract is \$2,000; colonoscopy is \$1,500. • <u>Preauthorization</u> by Anthem is required for arthroscopy, cataract & colonoscopy to avoid an additional 20% <u>coinsurance</u> for non-compliance.
	Physician/surgeon fees	15% <u>coinsurance</u>	50% <u>coinsurance</u> plus any <u>balance-billing</u> .	<u>Preauthorization</u> 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	<u>Emergency room care</u>	\$100 <u>copay/visit</u> plus 15% <u>coinsurance</u>	\$100 <u>copay/visit</u> plus 15% <u>coinsurance</u>	<ul style="list-style-type: none"> • <u>Copay</u> waived if admitted to the hospital. • Professional fees may be billed separately.
	<u>Emergency medical transportation</u>	15% <u>coinsurance</u>	Air ambulance services (if covered when furnished by a Participating Provider): 15% <u>coinsurance</u> Other: 20% <u>coinsurance</u> plus any <u>balance-billing</u> .	None.
	<u>Urgent care</u>	\$20 <u>copay/visit</u>	\$20 <u>copay/visit</u> plus 50% <u>coinsurance</u> plus any <u>balance-billing</u> .	This is for a non-hospital <u>urgent care</u> center. Professional fees may be billed separately.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% <u>coinsurance</u> of the 1st \$15,000 No cost for remainder of hospital stay	50% <u>coinsurance</u> of the 1st \$15,000 (20% <u>coinsurance</u> <i>if admission is due to an emergency or you live out-of-area</i>) plus any <u>balance-billing</u> .	<ul style="list-style-type: none"> • <u>Preauthorization</u> is required to avoid a 20% penalty. • Routine hip or knee replacement surgery limited to <i>maximum plan allowance</i> of \$30,000. • Use designated Value Based hospital facilities for MPA listed surgeries if you are a California resident. • No cost for remainder of hospital stay except for any <u>balance-billing</u> that a Non-Participating <u>provider</u> may charge you).
	Physician / surgeon fees	15% <u>coinsurance</u>	50% <u>coinsurance</u> plus any <u>balance-billing</u> .	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Benefit is covered at 100%. <u>Deductible</u> does not apply.	\$20 <u>copay</u> and 50% <u>coinsurance</u> /office visit 50% <u>coinsurance</u> for other outpatient services Plus any balance-billing	Contact Optum BHS for a list of participating <u>providers</u> . Non-Participating <u>providers</u> may balance bill you.
	Inpatient services	Benefit is covered at 100%. <u>Deductible</u> does not apply.	50% <u>coinsurance</u> (20% if emergency admission) of the 1st \$15,000. No cost for remainder of hospital stay except for any <u>balance-billing</u> .	<u>Preauthorization</u> 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	<ul style="list-style-type: none"> • <u>Cost sharing</u> does not apply for <u>preventive services</u>.

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)	
				<ul style="list-style-type: none"> • Prenatal care (other than ACA-required preventive screenings) is not covered for dependent children. • Depending on the type of services, a <u>copay</u>, <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	15% <u>coinsurance</u> of	50% <u>coinsurance</u> plus any <u>balance-billing</u>	<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 penalty of non-payment.
	Childbirth / delivery facility services	\$1,000 copay plus 15% <u>coinsurance</u> of the 1st \$15,000.	\$1,000 <u>copay</u> plus 50% <u>coinsurance</u> plus any <u>balance-billing</u> .	<ul style="list-style-type: none"> • <u>Copay</u> waived for participation in the “Future Moms” program. • Delivery expenses are not covered for dependent children except for an Emergency Medical Condition. • <u>Deductible</u> applies
If you need help recovering or have other special health needs	<u>Home health care</u>	15% <u>coinsurance</u>	50% <u>coinsurance</u> plus any <u>balance-billing</u>	<u>Preauthorization</u> by Anthem is required to avoid a penalty of non-payment.
	<u>Rehabilitation services</u>	15% <u>coinsurance</u>	50% <u>coinsurance</u> plus any <u>balance-billing</u>	<ul style="list-style-type: none"> • Inpatient <u>rehabilitation services</u> require <u>preauthorization</u> by Anthem to avoid a penalty of no payment. • Outpatient rehabilitation (physical/speech/occupational) services require <u>preauthorization</u> by Anthem to avoid a 20% penalty.
	<u>Habilitation services</u>	Not covered	Not Covered	You pay 100% of these services, even in- <u>network</u> .
	<u>Skilled nursing care</u>	15% <u>coinsurance</u>	50% <u>coinsurance</u> plus any <u>balance-billing</u>	<u>Preauthorization</u> by Anthem is required to avoid a 20% penalty.
	<u>Durable medical equipment</u>	15% <u>coinsurance</u>	50% <u>coinsurance</u> plus any <u>balance-billing</u>	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.

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)	
	<u>Hospice services</u>	15% <u>coinsurance</u>	50% <u>coinsurance</u> plus any <u>balance-billing</u>	<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 <u>plan</u>
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Cosmetic Surgery • Dental care (may be covered under a separate dental plan) • <u>Habilitation services</u> • Infertility treatment 	<ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. • Non-preferred brand drugs • Private-duty nursing 	<ul style="list-style-type: none"> • Routine eye care (may be covered under a separate vision <u>plan</u>) • 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 <u>plan</u> document.)		
<ul style="list-style-type: none"> • 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) 	<ul style="list-style-type: none"> • Bariatric surgery (when <u>medically necessary</u>) • Chiropractic care (\$40 per visit up to 40 visits per <u>plan</u> year) 	<ul style="list-style-type: none"> • 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](http://www.healthcare.gov). For more information about the [Marketplace](http://www.healthcare.gov), 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 Board of Trustees for the Cement Masons Health and Welfare Trust Fund for Northern California, 4160 Dublin Blvd., Suite 400, 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.

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	\$60
Coinsurance	\$1,860
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,230

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	\$7,400
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$640
Coinsurance	\$320
What isn't covered	
Limits or exclusions	\$55
The total Joe would pay is	\$1,265

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	\$1,386
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$0
Coinsurance	\$289
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$539

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.