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.insulators16benefits.org or call 1-844-685-6409. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copay, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-844-685-6409 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	PPO and Non-PPO Providers combined: **$200**/individual or **$400**/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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. PPO online visit, hospice services, second surgical opinion, PPO transplants that are preauthorized by Anthem's case manager, outpatient prescription drugs, and dental/vision expenses covered under separate plans.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copay or coinsurance may apply.
Are there other deductibles for specific services?	Yes. $50/individual, $100/family if you elect the Delta Dental 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?	There is no out-of-pocket limit on all types of cost sharing, but there is a $2,500/individual limit on the amount of coinsurance that you must pay for covered services from a PPO provider in a year.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not applicable.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. See www.anthem.com/ca or call the Trust Fund Office at 1-844-685-6409 for a list of PPO providers.	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 **copay** 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 health care provider's office or clinic	Primary care visit to treat an injury or illness	Online visit: 10% coinsurance, deductible does not apply. Office visit: 10% coinsurance	Online visit: Not covered Office visit: 40% coinsurance	None.
	Specialist visit	10% coinsurance	40% coinsurance	None.
	Preventive care/screening/ immunization	Routine physical exam age 17 and over: No charge Routine physical exam through age 16, and other covered preventive services: 10% coinsurance	Routine physical exam age 17 and over: Not covered. Routine physical exam through age 16, and other covered preventive services: 40% coinsurance	• Routine physical examinations include laboratory services in connection with routine physical examination and immunizations, and are covered, subject to frequency limitations, for any age with a PPO provider, or if provided by a Non-PPO provider, through age 16 only. • Mammogram, pap test, and colonoscopy or sigmoidoscopy are subject to age, risk, and/or frequency limitations. • Colonoscopy and sigmoidoscopy covered for Employee and Spouse only. Colonoscopy limited to a maximum benefit of $1,500 per procedure when received from a Non-PPO provider.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	40% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	40% coinsurance	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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.elixirsolutions.com. For Mail Order visit www.costco.com or call 1-800-607-6861.	Generic drugs	Retail (up to 30-day supply): $5 copay/fill. Mail Order pharmacy (up to a 90-day supply): $10 copay/fill.	You must pay 100% up front and submit a claim for reimbursement of the in-network pharmacy cost less your in-network copay. You are responsible for the difference between the in-network pharmacy cost and the actual drug cost.	• Deductible does not apply. • Mail order is available for non-emergency extended-use maintenance drugs only. • Costco's preferred drug list does not affect your cost sharing. Some drugs on Costco's preferred drug list are not covered under this plan. *See the Schedule of Medical Benefits in your SPD for more information. • Drugs for the treatment of impotence and/or erectile dysfunction are limited to 6 doses/month. • If you are taking a drug for acne, androgens, diabetes (including glucose testing supplies, insulin and injectable anti-diabetic) or overactive bladder, the Fund will provide coverage only for the Preferred Formulary Alternative unless an exception has been approved. • Over-the-counter medications are not covered, with or without a prescription (except for insulin and Prilosec).
	Preferred Brand drugs	Retail (up to 30-day supply): 20% coinsurance, $10 minimum/ $40 maximum copay/fill. Mail Order pharmacy (up to a 90-day supply): 20% coinsurance, $10 minimum/$80 maximum copay/fill.		
	Non-Preferred Brand drugs	Retail (up to 30-day supply): 20% coinsurance, $10 minimum/ $60 maximum copay/fill. Mail Order pharmacy (up to a 90-day supply): 20% coinsurance, $10 minimum/$120 maximum copay/fill.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	Preauthorization required to avoid a 20% penalty.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	No charge (and deductible does not apply) for second surgical opinion.
If you need immediate medical attention	Emergency room care	10% coinsurance	Emergency Services: 10% coinsurance Non-Emergency Services: 40% coinsurance	Professional/physician charges may be billed separately. *See definitions chapter of SPD for more information on Emergency Services.
	Emergency medical transportation	10% coinsurance	40% coinsurance	• Covered for Emergency Services or for medically necessary inter-facility transport only. *See definitions chapter of SPD for more information on Emergency Services. • You pay 10% coinsurance for Non-PPO air ambulance Balance Billing will not apply.

* For more information about limitations and exceptions, see the plan document at www.insulators16benefits.org.

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	Urgent care	10% coinsurance	Emergency Services: 10% coinsurance Non-Emergency: 40% coinsurance	Professional/physician charges may be billed separately. *See definitions chapter of SPD for more information on Emergency Services.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	Elective admission requires preauthorization to avoid a 20% penalty. Private room not covered unless medically necessary.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	No charge (and deductible does not apply) for second surgical opinion.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Online visit: 10% coinsurance, deductible does not apply. Office visit and other outpatient services: 10% coinsurance	Online visit: Not covered. Office visit and other outpatient services: 40% coinsurance	None.
	Inpatient services	10% coinsurance	40% coinsurance	Elective admission requires preauthorization to avoid a 20% penalty.
If you are pregnant	Office visits	10% coinsurance	40% coinsurance	• Maternity care may include tests and services described somewhere else in the SBC (i.e. ultrasound). Not covered for dependent children. • Charges for amniocentesis are not covered unless the patient is 35 years or older, or if under age 35 has a previous afflicted child, and unless performed between the 14th and 16th week of pregnancy.
	Childbirth/delivery professional services	10% coinsurance	40% coinsurance	Not covered for dependent children.
	Childbirth/delivery facility services	10% coinsurance	40% coinsurance	Hospital stay longer than 48 hours for a vaginal delivery or 96 hours for a cesarean section requires preauthorization to avoid a 20% penalty. Not covered for dependent children.
If you need help recovering or have other special health needs	Home health care	No charge	No charge	Limited to 60 visits/year. Transitional care requires preauthorization to avoid a 20% penalty.
	Rehabilitation services	10% coinsurance	40% coinsurance	Outpatient physical, occupational, and speech therapy is limited to a combined 20 visits/year. Limit does not apply to mental health/substance use

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)	
				disorder. Speech therapy covered only for a participant who lost normal speech due to illness or injury, and autism treatment. Inpatient rehabilitation requires preauthorization to avoid a 20% penalty.
	Habilitation services	10% coinsurance	40% coinsurance	Coverage limited to medically necessary treatment of a mental health disorder. Other services are not covered by the plan.
	Skilled nursing care	10% coinsurance	40% coinsurance	Preauthorization required to avoid a 20% penalty. Limited to 60 days/year.
	Durable medical equipment	10% coinsurance	40% coinsurance	Purchase is covered only if the cost is less than rental for the period required.
	Hospice services	No charge, deductible does not apply.	No charge, deductible does not apply.	Limited to 30 days/lifetime. Respite care limited to 5 days/30-day period. Transitional care requires preauthorization to avoid a 20% penalty.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	If you elect vision benefits, coverage will be provided 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 benefits, coverage will be provided under a separate dental plan through Delta Dental.

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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult) (may be available under separate dental plan)
- Habilitation services (except medically necessary treatment of a mental health disorder)
- Infertility treatment
- Non-emergency care when traveling outside of U.S.
- Routine eye care (Adult) (may be available under separate vision plan)
- Routine foot care
- Weight loss programs

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

- Bariatric surgery (preauthorization required)
- Chiropractic care (limited to 20 visits/year)
- Hearing aids (up to $1,500/ear every 3 years with a prescription)
- Long-term care (if acute, 60 days/calendar year)
- Private-duty nursing (limited to 100 visits/lifetime)

* For more information about limitations and exceptions, see the plan document at www.insulators16benefits.org.

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 1-844-685-6409. 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 1-844-685-6409.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-685-6409.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-844-685-6409.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-685-6409.

Because the Indemnity Plan is a "grandfathered health plan," we are required by law to provide this notice to you:

This group health plan believes the indemnity medical plan sponsored by **Heat and Frost Insulators of Northern California Local Union 16 Health and Welfare Plan** is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted.

Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Administrative Office.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or **www.dol.gov/ebsa/healthreform**. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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, copays 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** **$200**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance (diagnostic tests)** **10%**

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	$200
Copays	$10
Coinsurance	$1,240
What isn't covered	
Limits or exclusions	$110
The total Peg would pay is	**$1,560**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$200**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance (prescription drug)** **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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copays	$240
Coinsurance	$590
What isn't covered	
Limits or exclusions	$410
The total Joe would pay is	**$1,440**

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

- **The plan's overall deductible** **$200**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance (diagnostic tests)** **10%**

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	$200
Copays	$10
Coinsurance	$260
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$470**

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

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