**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, call 1-800-433-6692. 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 https://www.healthcare.gov/sbc-glossary/ or call 1-800-433-6692 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$200**/person PPO Provider; **$400**/family PPO Provider<br>**$400**/person Non-PPO; **$800**/family Non-PPO<br>Does not apply to charges incurred for accidents, confinement in a PPO hospital, a birthing center, in connection with Hospice Care, chiropractic care, prescription drugs, vitamins and minerals prescribed by a physician, smoking cessation program benefits and routine physical exams. | 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, Preventive care and primary care services are covered before you meet your deductible. | 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-beneifits/. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | The maximum out of pocket for PPO medical expenses will be $3,000 per individual or $6,000 per family and excludes charges payable at 50%, unless required by law (non-PPO charges except emergency) but includes the PPO deductible. The maximum out of pocket for prescription benefit expenses will be $3,600 per individual or $7,200 per family covered. In no event will the combined maximum out of pocket for medical and prescription drug expenses exceed $6,600 per individual and $13,200 per 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. For medical plan participating providers, once you have incurred $15,000 of covered expenses including the deductible, the plan will pay 100% of participating provider medical expenses incurred for the remainder of the plan year. The out of pocket limit under the medical plan excludes charges payable at a rate of 50%. |
| **What is not included in the out-of-pocket limit?** | The deductible for non-PPO providers, charges for services provided by non-PPO providers, premiums, and balance billing charges except where prohibited by law. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See www.anthem.com/ca or www.bcbs.com (out of CA) or call the Fund Office for a list of participating providers in the Anthem Blue Cross network in CA or 1-800-810-BLUE (out of CA). | 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 |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network 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 | 15% coinsurance | 50% coinsurance | 20% coinsurance for PPO out of area |
| | Specialist visit | 15% coinsurance | 50% coinsurance | 20% coinsurance for PPO out of area |
| | Preventive care/screening/ immunization | No charge | 50% coinsurance | 20% coinsurance for PPO out of area. 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) | 15% coinsurance | 50% coinsurance | 20% coinsurance for PPO out of area; services provided by a chiropractor are limited to 20 visits each calendar year. |
| | Imaging (CT/PET scans, MRIs) | 15% coinsurance | 50% coinsurance | 20% coinsurance for PPO out of area |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.OptumRx.com | Generic drugs | 20% coinsurance | Not Covered | Coverage may be subject to Utilization Management Review. If a generic drug is available as a substitution for a brand name drug, the Plan will only provide coverage for the generic drug. You will be responsible for the 20% coinsurance for the generic drug equivalent and 100% of the cost difference between the brand name and the generic drug. The cost difference is considered a penalty and will not count toward the annual out of pocket limits. |
| | Preferred brand drugs | 20% coinsurance | Not Covered | |
| | Non-preferred brand drugs | 20% coinsurance | Not Covered | |
| | Specialty drugs | 20% coinsurance | Not Covered | Coverage may be subject to Utilization Management Review. If a generic drug is available as a substitution for the brand name drug, the Plan will only provide coverage for the generic drug. You will be responsible for the 20% coinsurance from the generic drug equivalent and 100% of the cost difference between the brand name and the generic drug. The cost difference is considered a penalty and will not count toward the annual out of pocket limits. To be covered, specialty drugs must be dispensed through an OptumRx specialty pharmacy. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 15% coinsurance | 50% coinsurance | 20% coinsurance for PPO out of area |
| | Physician/surgeon fees | 15% coinsurance | 50% coinsurance | 20% coinsurance for PPO out of area –In some instances, services provided by an out of network provider at an in-network facility may be payable at 15% coinsurance. |
| **If you need immediate medical attention** | Emergency room care | 15% coinsurance | 15% coinsurance | 15% coinsurance for PPO out of area |
| | Emergency medical transportation | 15% coinsurance | 50% coinsurance<br>15% coinsurance for Air Ambulance | 15% coinsurance for PPO out of area |
| | Urgent care | 15% coinsurance | 50% coinsurance | 20% coinsurance for PPO out of area |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 15% coinsurance | 50% coinsurance | 20% coinsurance for PPO out of area |
| | Physician/surgeon fees | 15% coinsurance | 50% coinsurance; except qualifying services from Non-PPO Providers rendered at PPO facilities will be payable as a PPO Provider expense (15% coinsurance) | 20% coinsurance for PPO out of area |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 15% coinsurance | 50% coinsurance | 20% coinsurance for PPO out of area |
| | Inpatient services | 15% coinsurance | 50% coinsurance | 20% coinsurance for PPO out of area |
| **If you are pregnant** | Office visits | No charge | 50% coinsurance | Cost sharing does not apply for preventive services. Depending on the type of service, a coinsurance may apply. Maternity care may include tests and services described somewhere else in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 15% coinsurance | 50% coinsurance | |
| | Childbirth/delivery facility services | 10% coinsurance | 10% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 15% coinsurance | 50% coinsurance | Prior Authorization Required by Anthem Blue Cross |
| | Rehabilitation services | 20% coinsurance | 50% coinsurance | None |
| | Habilitation services | 20% coinsurance | 50% coinsurance | None |
| | Skilled nursing care | 20% coinsurance | 20% coinsurance | Covered expenses limited to 50% of the transferring hospital's average semi-private room rate and limited to 50 days per confinement. |
| | Durable medical equipment | 15% coinsurance | 50% coinsurance | 15% coinsurance for PPO out of area |
| | Hospice services | No charge | No charge | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If your child needs dental or eye care** | Children's eye exam (VSP) | $20 copay/visit | Not Covered | Limited to one exam per year |
| | Children's glasses (VSP) | No Charge | Not Covered | Limited to one pair of glasses every two years (lenses once per year) |
| | Children's dental check-up (Fee for Service Dental) | No Charge | Not Covered | Limited to two check-ups per year |

## 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
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside The U.S.
- Private-duty nursing
- 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.)**

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric surgery
- Chiropractic care
- Dental Care (for adults and children) provided under the First Dental Health Plan
- Routine Eye Care (for adults and Children). Vision benefits are provided under the Vision Service Plan

**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 Department of Labor Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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.

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

**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 Administrator at 1-800-433-6692 or Department of Labor 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 1-800-433-6692

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-433-6692.

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-433-6692.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-433-6692.

*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 | $200 |
| 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 | $200 |
| Copayments | $0 |
| Coinsurance | $1,866 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,126** |

### 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 | 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** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $200 |
| Copayments | $0 |
| Coinsurance | $1,000 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,220** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| 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** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $0 |
| Copayments | $0 |
| Coinsurance | $2,380 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$420** |

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: [insert].
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.