



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, refer to the Summary Plan Description located at the Trust Funds' website: www.norcalaborers.org or by calling 1-800-244-4530. 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.norcalaborers.org or call 1-800-244-4530 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	\$150 /individual or \$450 /family. 03/01-2/28.	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 <u>deductible</u>?	Yes. Inpatient hospital services, routine physical exams, well baby visits to 24 months of age or the prescription drug benefit.	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.
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 plan?	\$3,000 /individual or \$6,000 /family. Participating providers (PPO) only.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.
What is not included in the <u>out-of-pocket limit</u>?	Premiums, balance-billed charges, health care this plan doesn't cover, <u>copayments</u> , <u>coinsurance</u> on non-PPO <u>provider</u> claims.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. The Anthem Blue Cross Prudent Buyer Plan Network. See www.anthem.com/ca for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>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 provider's charge 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.	You can see any <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
		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 <u>copay</u> /visit	\$15 <u>copay</u> /visit plus 30% <u>coinsurance</u>	Whenever you use a non-PPO for covered services, in addition to the 30% <u>coinsurance</u> , you also pay all charges that exceed the allowed amounts.
	<u>Specialist</u> visit	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	Excess of \$40/visit, 20 visits/Plan Year for chiropractor and 10% <u>coinsurance</u> for acupuncture	Same as participating provider for chiropractor and 30% <u>coinsurance</u> for acupuncture	You pay anything in excess of \$40 per visit and anything in excess of 20 visits per Plan Year for chiropractor. Acupuncture limited to the treatment of pain.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	X-rays performed by a chiropractor are limited to \$100 per Plan Year.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Whenever you use a non-PPO for any covered service, in addition to the 30% <u>coinsurance</u> , you also pay all charges that exceed the allowed amounts.
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 <u>copay</u> /prescription Retail* or \$20 <u>copay</u> /prescription Mail Order	\$10 <u>copay</u> /prescription Retail* plus excess of contract amount	30-day supply Retail; 90-day supply Mail Order. *Double <u>copay</u> after 3 rd fill Retail.
	Preferred brand drugs	\$20 <u>copay</u> /prescription Retail* or \$40 <u>copay</u> /prescription Mail Order	\$20 <u>copay</u> /prescription Retail* plus excess of contract amount	Same as generic drugs.
	Non-preferred brand drugs	\$30 <u>copay</u> /prescription Retail* or \$60 <u>copay</u> /prescription Mail Order	\$30 <u>copay</u> /prescription Retail* plus excess of contract amount	Same as generic drugs.
	<u>Specialty drugs</u>	\$20 <u>copay</u> /injectable meds; oral meds same as above for generic, preferred/non-preferred	Not covered	Must use contracting <u>provider</u> BriovaRx for all <u>specialty drugs</u> .

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)	10% <u>coinsurance</u>	Excess of \$500/day	You pay all charges in excess of \$500/day if you use a non-PPO. For hospital-based outpatient surgery facilities, the maximum plan allowance for arthroscopy is \$6,000; cataract is \$2,000; colonoscopy is \$1,500.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$25 <u>copay</u> /visit plus 10% <u>coinsurance</u>	\$50 <u>copay</u> /visit plus 30% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u> or 10% <u>coinsurance</u> if life-threatening	Whenever you use a non-PPO for covered services, in addition to the 30% <u>coinsurance</u> , you also pay all charges that exceed the allowed amounts.
	<u>Urgent care</u>	\$15 <u>copay</u> /visit	\$15 <u>copay</u> /visit plus 30% <u>coinsurance</u>	This is for non-hospital urgent care center. Whenever you use a non-PPO for any covered service, in addition to the 30% <u>coinsurance</u> , you also pay all charges that exceed the allowed amounts.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u> of first \$10,000 and no cost for remainder of hospital stay	30% <u>coinsurance</u> of first \$10,000 Covered Charges and no cost for Covered Charges for remainder of stay	*10% <u>coinsurance</u> of first \$10,000 if non-PPO is due to an emergency or residence is outside of a PPO service area. Utilization review required for all hospital admissions. Coinsurance of 20% of first \$10,000 for non-compliance (non-PPO only). Routine hip or knee replacement surgery limited to maximum plan allowance of \$30,000. Use designated hospital facilities for hip or knee replacement surgery.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Whenever you use a non-PPO for covered services, in addition to the 30% <u>coinsurance</u> , you also pay all charges that exceed the allowed amounts.

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 need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 <u>copay</u> /office visit and 10% <u>coinsurance</u> other outpatient services	\$15 <u>copay</u> plus 30% <u>coinsurance</u> /office visit and 30% <u>coinsurance</u> other outpatient services	Plus, up to three (3) no-cost visits per incident per Plan Year through the EAP program. Only upon referral and only in-network <u>providers</u> .
	Inpatient services	10% <u>coinsurance</u> of first \$10,000 and no costs for remainder of hospital stay	30% <u>coinsurance</u> * of first \$10,000 Covered Charges and no cost for Covered Charges for remainder of hospital stay	*10% <u>coinsurance</u> of first \$10,000 if non-PPO is due to an emergency or residence is outside of a PPO service area. Utilization review required for all hospital admissions. Coinsurance of 20% of first \$10,000 for non-compliance (non-PPO only).
If you are pregnant	Office visits	No charge	No charge	Pregnancy is not covered for dependent children.
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Pregnancy is not covered for dependent children.
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Inpatient <u>coinsurance</u> 10%/30% of first \$10,000, no cost for remainder of hospital stay. Utilization review required if length of stay is more than 48 hours for general delivery or 96 hours for c-section.
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None.
	<u>Habilitation services</u>	Not covered	Not covered	You pay 100% of these expenses.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Same as facility fee if you have a hospital stay (see page 3).
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Must be prescribed by a physician.
	<u>Hospice services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	May be covered under a separate vision <u>plan</u> .
	Children's glasses	Not covered	Not covered	May be covered under a separate vision <u>plan</u> .
	Children's dental check-up	Not covered	Not covered	May be covered under a separate dental <u>plan</u> .

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	<ul style="list-style-type: none">• Long-term care• Non-emergency care when traveling outside the U.S.• Private duty nursing• Routine eye care (may be covered under a separate vision plan)	<ul style="list-style-type: none">• Routine foot care• Specialty drugs from a non-contracting pharmacy/facility• Weight-loss programs
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)• Bariatric surgery (when medically necessary)	<ul style="list-style-type: none">• Chiropractic care	<ul style="list-style-type: none">• Hearing aids

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 plan at 1-800-244-4530; your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa; or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or www.cciio.cms.gov. Other options to continue coverage are 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 Laborers Health and Welfare Trust Fund for Northern California, 220 Campus Lane, Fairfield, CA 94534-1498. You may also contact the Department of Labor at www.dol.gov/ebsa.healthcarereform or 1-866-444-3272.

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 1-800-244-4530.

————— *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 \$150
- Specialist copayment \$0
- Hospital (facility) coinsurance 10%
- Other coinsurance 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	\$12,730
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$150
Copayments	\$33
Coinsurance	\$1,247
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,490

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

- The plan's overall deductible \$150
- Specialist copayment \$0
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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	\$7,389
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$150
Copayments	\$619
Coinsurance	\$229
<i>What isn't covered</i>	
Limits or exclusions	\$255
The total Joe would pay is	\$1,253

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

- The plan's overall deductible \$150
- Specialist copayment \$15
- Hospital (facility) coinsurance 10%
- Other coinsurance 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	\$1,925
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$150
Copayments	\$15
Coinsurance	\$170
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$335

The Laborers Health and Welfare Trust Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Language	Message about Language Assistance
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 707-864-2800.
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 707-864-2800。
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 707-864-2800.
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 707-864-2800.
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 707-864-2800. 번으로 전화해 주십시오.
Armenian	ՈՒՇԱԴՐՈՒԹՅՈՒՆՆԵՐ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Ձանգահարեք 707-864-2800.
Persian (Farsi)	رایگان به صورت زبانی توسط سه یلات کزید، می گفتمگو فارسی زبان بهرگانا: توجهت به گزیرید. تماس با شد. بامی فراهم 707-864-2800 شما به رای
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 707-864-2800.
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。707-864-2800 まで、お電話にてご連絡ください。
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 707-864-2800.
Punjabi	ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤਾਮਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 707-864-2800. 'ਤੇ ਕਾਲ ਕਰੋ।
Mon-Khmer, Cambodian	ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាដោយមិនគិតល្អលគឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 707-864-2800 ។
Hmong	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 707-864-2800.
Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 707-864-2800. पर कॉल कर_।
Thai	ความสนใจ: ถ้าคุณพูดภาษาไทย, บริการให้ความช่วยเหลือภาษาฟรีที่มีอยู่ โทร 707-864-2800.