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: lfao.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 lfao.org or call 1-800-244-4530 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$150**/individual or **$450**/family. 03/01-2/28.	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.** Inpatient hospital services, routine physical exams, well baby visits to 24 months of age or the prescription drug benefit.	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-benefits/
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?	**$3,000**/individual or **$6,000**/family. Participating providers (PPO) only.	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, copayments, coinsurance on non-PPO provider claims.	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.** The Anthem Blue Cross Prudent Buyer Plan Network. See www.anthem.com/ca for a list of network 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 any 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 copay /visit	$15 copay/visit plus 30% coinsurance	Whenever you use a non-PPO for covered services, in addition to the 30% coinsurance, you also pay all charges that exceed the allowed amounts.
	Specialist visit	10% coinsurance	30% coinsurance	None
	Preventive care/screening/ immunization	No charge	30% coinsurance	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-benefits/
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Whenever you use a non-PPO for any covered service, in addition to the 30% coinsurance, you also pay all charges that exceed the allowed amounts.
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 copay/prescription Retail* or $20 copay/prescription Mail Order	$10 copay/prescription Retail* plus excess of contract amount	30-day supply Retail; 90-day supply Mail Order. *Double copay after 3rd fill Retail.
	Preferred brand drugs	$20 copay/prescription Retail* or $40 copay/prescription Mail Order	$20 copay/prescription Retail* plus excess of contract amount	Same as generic drugs.
	Non-preferred brand drugs	$30 copay/prescription Retail* or $60 copay/prescription Mail Order	$30 copay/prescription Retail* plus excess of contract amount	Same as generic drugs.

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)	
	Specialty drugs	$20 copay/injectable meds; oral meds same as above for generic, preferred/non-preferred	Not covered	Must use contracting provider BriovaRx for all specialty drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	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% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$25 copay/visit 1, 2, 3 $50 copay thereafter plus 10% coinsurance	$25 copay/visit 1, 2, 3 $50 copay thereafter plus 30% coinsurance	You pay the higher $50 copay after 3 visits per calendar year.
	Emergency medical transportation	10% coinsurance	30% coinsurance or 10% coinsurance if life-threatening	Whenever you use a non-PPO for covered services, in addition to the 30% coinsurance, you also pay all charges that exceed the allowed amounts.
	Urgent care	10% coinsurance	30% coinsurance	This is for non-hospital urgent care center. Whenever you use a non-PPO for any covered service, in addition to the 30% coinsurance, you also pay all charges that exceed the allowed amounts.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance of first $10,000 and no cost for remainder of hospital stay	30% coinsurance of first $10,000 Covered Charges and no cost for Covered Charges for remainder of stay	*10% coinsurance 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% coinsurance	30% coinsurance	Whenever you use a non-PPO for covered services, in addition to the 30% coinsurance,

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)	
				you also pay all charges that exceed the allowed amounts.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/office visit and 10% coinsurance other outpatient services	$15 copay plus 30% coinsurance/office visit and 30% coinsurance 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 providers.
	Inpatient services	10% coinsurance of first $10,000 and no costs for remainder of hospital stay	30% coinsurance* of first $10,000 Covered Charges and no cost for Covered Charges for remainder of hospital stay	*10% coinsurance 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% coinsurance	30% coinsurance	Pregnancy is not covered for dependent children.
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	Inpatient coinsurance 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	Home health care	10% coinsurance	30% coinsurance	Preauthorization required.
	Rehabilitation services	10% coinsurance	30% coinsurance	None.
	Habilitation services	Not covered	Not covered	You pay 100% of these expenses.
	Skilled nursing care	10% coinsurance	30% coinsurance	Same as facility fee if you have a hospital stay (see page 3).
	Durable medical equipment	10% coinsurance	30% coinsurance	Must be prescribed by a physician.
	Hospice services	10% coinsurance	30% coinsurance	Preauthorization required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	May be covered under a separate vision plan.
	Children's glasses	Not covered	Not covered	May be covered under a separate vision plan.
	Children's dental check-up	Not covered	Not covered	May be covered under a separate dental 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.)

- Cosmetic surgery
- Dental care (may be covered under a separate dental plan
- Habilitation services
- Infertility treatment
- 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)
- 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.)

- Acupuncture (if prescribed for the treatment of pain)
- Bariatric surgery (when medically necessary)
- Chiropractic care
- 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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$150
Copayments	$33
Coinsurance	$1,247
What isn't covered	
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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$150
Copayments	$619
Coinsurance	$229
What isn't covered	
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**

In this example, Mia would pay:

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

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

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	ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 707-864-2800.
Persian (Farsi)	توجه: اگر به زبان فارسی گفتگو می‌کنید، تسهیلات زبانی به صورت رایگان برای شما فراهم می‌باشد. با 707-864-2800 تماس بگیرید.
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 ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 707-864-2800. 'ਤੇ ਕਾਲ ਕਰੋ।
Mon-Khmer, Cambodian	ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ 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.