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 deductible?	$1,000/person, $3,000/family per calendar year (or $250/person, $750/family per calendar year if enrolled in the Plan's Promise Program). _____ _____	Generally, you must pay all 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, ACA Preventive Care and a routine physical exam with a Participating Provider 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-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?	***Medical Participating Providers:*** $3,000 person/$6,000 family per calendar year. ***In-Network Prescription Drugs:*** $1,000 person/$3,000 Family per calendar year.	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.
What is not included in the out-of-pocket limit?	Medical Out-of-Pocket Limit does not include: Premiums, balance-billing charges, health care this plan doesn't cover, copays, deductible, coinsurance on non-Participating claims, penalties for failure to obtain preauthorization, outpatient prescription drugs and amounts over the Maximum Plan Allowance (MPA) for certain services. Prescription Drug Out-of-Pocket Limit does not include: Medical charges, premiums, balance billing charge, healthcare this plan doesn't cover and Out-of-Network prescription drugs.	Even though you pay these expenses, they don't count toward the **out-of-pocket** limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See: **www.anthem.com/ca** or call 1-866-755-2680.	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 of 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 copay/visit, Deductible does not apply if enrolled in the Plan's Promise Program	$20 copay/visit plus 50% coinsurance plus any balance-billing that a Non-Participating provider may charge you.	. None
	Specialist visit	15% coinsurance if you participate in the Promise Program, otherwise 20% coinsurance	50% coinsurance plus any balance-billing that a Non-Participating provider may charge you.	If you participate in the wellness program, you must receive Preauthorization from PHA for certain specialty services in order to avoid a 20% penalty. See page 57 of your SPD/Plan Document for details.
	Preventive care/screening/ immunization	Services mandated by Health Reform: No charge. Deductible does not apply. Other immunizations: 15% coinsurance if you participate in the Promise Program, otherwise 20% coinsurance	$20 copay plus 50% coinsurance per office visit & 50% coinsurance for other covered preventive care services (including immunizations not required by health reform) plus any balance-billing that a Non-Participating provider may charge you.	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. **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	Diagnostic test (x-ray, blood work)	15% coinsurance if you participate in the Promise Program, otherwise 20% coinsurance	50% coinsurance plus any balance-billing that a Non-Participating provider may charge you.	X-rays associated with spinal manipulation services limited to $300/ Calendar Year.
	Imaging (CT/PET scans, MRIs)	15% coinsurance if you participate in the Promise Program, otherwise 20% coinsurance	50% coinsurance plus any balance-billing that a Non-Participating provider may charge you.	Preauthorization by PHA is required to avoid an additional 20% coinsurance for non-compliance.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.OptumRx.com	Generic drugs	$5 copay/prescription Retail or $10 copay/prescription Mail Order if you participate in the Promise Program, otherwise $10 copay/prescription Retail or $20 copay/prescription Mail Order.	You pay 100%. Plan reimburses based on the contract rate for an In-Network Pharmacy less any copay.	• Deductible does not apply. • 30-day supply Retail; 90-day supply Mail Order. • **Double copay** Retail after 3rd fill. • ACA preventive care drugs are not covered if purchased at a Non-Network pharmacy. • No charge for FDA-approved generic contraceptives (or brand name if generic is medically inappropriate).
	Preferred brand drugs	$25 copay/prescription Retail or $50 copay/prescription 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-Network Pharmacy.
	Specialty drugs	$25 copay/injectable meds. Oral meds same as above for generic or preferred brand	Not covered	Deductible does not apply. Must use contracting provider (BriovaRx) for all specialty drugs.

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance if you participate in the Promise Program, otherwise 20% coinsurance	You pay the excess of $500/day	• You pay all charges in excess $500/day if you use a non-PPO ambulatory surgery center. • For hospital based outpatient surgery facilities, the maximum plan allowance for arthroscopy is $6,000; cataract is $2,000; colonoscopy is $1,500. • Preauthorization by PHA required for arthroscopy, cataract & colonoscopy to avoid an additional 20% coinsurance for non-compliance.
	Physician/surgeon fees	15% coinsurance if you participate in the Promise Program, otherwise 20% coinsurance	50% coinsurance plus any balance-billing that a Non-Participating provider may charge you.	Preauthorization by a PHA is required for arthroscopy, cataract & colonoscopy to avoid an additional 20% penalty.
If you need immediate medical attention	Emergency room care	$100 copay/visit plus 15% coinsurance if you participate in the Promise Program, otherwise $100 copay/visit plus 20% coinsurance	$100 copay/visit plus 20% coinsurance plus any balance-billing that a Non-Participating provider may charge you.	Copay waived if admitted to the hospital. Professional fees may be billed separately.
	Emergency medical transportation	15% coinsurance if you participate in the Promise Program, otherwise 20% coinsurance	20% coinsurance plus any balance-billing that a Non-Participating provider may charge you.	None.
	Urgent care	$20 copay/visit	$20 copay/visit plus 50% coinsurance plus any balance-billing that a Non-Participating provider may charge you.	This is for a non-hospital urgent care center. Professional fees may be billed separately.

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 hospital stay	Facility fee (e.g., hospital room)	15% coinsurance of the 1st $15,000 if you participate in the Promise Program, otherwise 20% coinsurance. No cost for remainder of hospital stay	50% (15% if admission is due to an emergency or live out-of-area and you are enrolled in the Promise Program, otherwise 20%) of 1st $15,000. No cost for remainder of hospital stay (except for any balance-billing that a Non-Participating provider may charge you).	Preauthorization by Anthem is required to avoid a 20% penalty.. Routine hip or knee replacement surgery limited to maximum plan allowance of $30,000. Use designated hospital facilities for hip or knee replacement surgery and you live within California.
	Physician/surgeon fees	15% coinsurance if you participate in the Promise Program, otherwise 20% coinsurance	50% coinsurance plus any balance-billing that a Non-Participating provider may charge you.	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Benefit is covered at 100%. Deductible does not apply. This will be effective October 1, 2022.	$20 copay plus 50% coinsurance/office visit and 50% coinsurance for other outpatient services plus any balance-billing that a Non-Participating provider may charge you.	None.
	Inpatient services	Benefit is covered at 100%. Deductible does not apply. This will be effective October 1, 2022.	50% (20% if emergency admission) coinsurance of 1st $15,000. No cost for remainder of hospital stay (except any balance-billing that a Non-Participating provider may charge you).	Preauthorization by Optum is required to avoid a 20% penalty.
If you are pregnant	Office visits	Included in delivery and facility services	Included in delivery and facility services	• Cost sharing does not apply for preventive services. • Prenatal care (other than ACA-required preventive screenings) is not covered for dependent children. • Depending on the type of services, a copay, coinsurance, or deductible may apply. • Maternity care may include tests and services

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)	
				described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services Childbirth/delivery facility services	$1,000 copay plus 15% coinsurance of first $15,000 if enrolled in the Promise Program, otherwise $1,000 copay plus 20% coinsurance.	$1,000 copay plus 50% coinsurance plus any balance-billing that a Non-Participating provider may charge you.	• Preauthorization by Anthem required for inpatient stays exceeding 24 hours for a vaginal delivery/48 hours for a C-section to avoid a non-payment penalty.. • Copay waived for participation in the "Future Moms" program – 866-664-5404 • Delivery expenses are not covered for dependent children.
If you need help recovering or have other special health needs	Home health care	15% coinsurance if you participate in the Promise Program, otherwise 20% coinsurance	50% coinsurance plus any balance-billing that a Non-Participating provider may charge you.	Preauthorization by Anthem is required to avoid a penalty of non-payment.
	Rehabilitation services	15% coinsurance if you participate in the Promise Program, otherwise 20% coinsurance	50% coinsurance plus any balance-billing that a Non-Participating provider may charge you.	Inpatient rehabilitation services require preauthorization by Anthem to avoid a penalty of no payment. Outpatient rehabilitation (physical/speech/occupational) services require preauthorization by PHA to avoid a 20% penalty.
	Habilitation services	Not covered	Not Covered	You pay 100% of these services, even in-network.
	Skilled nursing care	15% coinsurance if you participate in the Promise Program, otherwise 20% coinsurance	50% coinsurance plus any balance-billing that a Non-Participating provider may charge you.	Preauthorization by Anthem is required to avoid a 20% penalty.
	Durable medical equipment	15% coinsurance if you participate in the Promise Program, otherwise 20% coinsurance	50% coinsurance plus any balance-billing that a Non-Participating provider may charge you.	Requires a physician's prescription. If you participate in the wellness program, charges of $500 or more require preauthorization by a Care Counselor in order to avoid a 20% penalty.

	Hospice services	15% coinsurance if you participate in the Promise Program, otherwise 20% coinsurance	50% coinsurance plus any balance-billing that a Non-Participating provider may charge you.	Preauthorization by Anthem is required to avoid a penalty of non-payment.

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 your child needs dental or eye care	Children's eye exam	Not covered	Not covered	May be covered under separate vision plan
	Children's glasses	Not covered	Not covered	May be covered under separate vision plan
	Children's dental check-up	Not covered	Not covered	May be covered under 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.
- Non-preferred brand drugs
- Private-duty nursing
- Routine eye care (may be covered under a separate vision plan)
- 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 plan document.)

- 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)
- Bariatric surgery (when medically necessary)
- Chiropractic care ($40 per visit up to 40 visits per plan year)
- 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. 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 Cement Masons Health and Welfare Trust Fund for Northern California, 1600 Harbor Bay Parkway, Suite 200, Alameda, CA 94502. 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**

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 888-245-5005.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are j ust 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	**$1,000**
Specialist *(coinsurance)*	**20%**
Hospital (facility) (coinsurance)	**20%**
Other	**20%**

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	**$12,731**

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
The plan's overall deductible	**$1,000**
Specialist *(coinsurance)*	**20%**
Hospital (facility) (coinsurance)	**20%**
Other	**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	**$7,400**

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
The plan's overall deductible	**$1,000**
Specialist *(coinsurance)*	**20%**
Hospital (facility) *(coinsurance)]*	**20%**
Other	**20%**

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**

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

In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$635
Coinsurance	$585
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,275**

In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$0
Coinsurance	$385
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,385**

Note: These numbers assume the patient does not participate in the plan's "Promise" Program. If you participate in the plan's "Promise" program, you may be able to reduce your costs. For more information about the "Promise" program, please contact the Trust Fund Office at 888-245-5005.