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, please contact the Trust Fund Office at 1-408-288-4400 or visit http://local467benefits.com/ppo . 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.https://www.healthcare.gov/sbc-glossary or call 1-408-288-4400 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$50**/individual or **$150**/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 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 is 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.
Are there other deductibles for specific services?	**Yes. $50**/individual or **$200**/family per lifetime for covered dental benefits.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For preferred providers **$2,050**/individual; for non-preferred providers **No Limit**.	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?	Deductibles/co-payments for non-preferred providers, prescription co-payments, drug addiction & alcohol or chemical dependency, premiums, balance-billing charges, and health care this plan doesn't cover.	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/health-insurance/provider-directory or call the Trust Fund Office at 1-408-288-4400 or Anthem Blue Cross at 1-800-688-3828 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 preferred provider network. You will pay the most if you use an non-preferred 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 preferred provider might use an non- preferred 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.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

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 Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance of PPO rate.	40% coinsurance of UCR plus any charges above UCR.	
	Specialist visit	10% coinsurance of PPO rate	40% coinsurance of UCR plus any charges above UCR	None
	Preventive care/screening/ immunization	10% coinsurance of PPO rate. No Charge COVID-19 vaccination.	40% coinsurance of UCR plus any charges above UCR. No Charge COVID-19 Vaccination.	Limited to one physical exam/every 12 months.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance of PPO rate.	40% coinsurance of UCR plus any charges above UCR.	
	Imaging (CT/PET scans, MRIs)	10% coinsurance of PPO rate	40% coinsurance of UCR plus any charges above UCR	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.navitus.com or call 1- 844-268-9789.	Generic drugs	10% coinsurance or $5 copay/prescription (retail & mail order)	Non-Participating pharmacies not covered.	Covers up to a 30-day supply (retail subscription); up to 90 day supply (mail order prescription).
	Preferred brand drugs	10% coinsurance or $5copay/prescription (retail & mail order)	Non-Participating pharmacies not covered.	Covers up to a 30-day supply (retail subscription); up to 90 day supply (mail order prescription).
	Non-preferred brand drugs	10% coinsurance or $5copay/prescription (retail	Non-Participating pharmacies not covered.	Covers up to a 30-day supply (retail subscription); up to 90 day supply (mail order prescription).

[* For more information about limitations and exceptions, see the plan or policy document at www.local467benefits.com .]

Common Medical Event	Services You May Need	What You Will Pay Preferred Provider (You will pay the least)	What You Will Pay Non-Preferred Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		& mail order)		
	Specialty drugs	10% coinsurance or $5copay/prescription (retail & mail order)	Non-Participating pharmacies not covered.	Covers up to a 30-day supply (retail subscription); up to 90 day supply (mail order prescription).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance of PPO rate	40% coinsurance of UCR plus any charges above UCR	None
	Physician/surgeon fees	10% coinsurance of PPO rate	40% coinsurance of UCR plus any charges above UCR	None
If you need immediate medical attention	Emergency room care Emergency medical transportation Urgent care	10% coinsurance of PPO rate	Per No Surprise Act, emergency services covered the same as PPO Network , 10 % coinsurance of PPO rate	Any Non-PPO emergency cost-sharing will count towards any Plan applicable deductible or out-of-pocket limit similar to PPO network emergency care. Emergency includes treatment received in Independent Free standing emergency department.
If you have a hospital stay	Facility fee (e.g., hospital room) Physician/surgeon fees	10% coinsurance of PPO rate	40% coinsurance of UCR plus any charges above UCR except for No Surprise Act covered services same as PPO Network provider	Certain **non-emergency services** & **ancillary services** (ex. emergency medicine, anesthesia, pathology, radiology, lab, neonatology, assistant surgeon, hospitalist or intensivist services) received by out-of-network provider at network hospital you cannot be billed more than the plan's network contract rate. However, there are certain other non-emergency services and post-stabilization services at these network facilities, you can give written consent to be balance billed. Contact the Trust Fund Office for more information.
If you need mental health, behavioral	Outpatient services	10% coinsurance of PPO rate	40% coinsurance of UCR plus any charges above UCR except for No Surprise Act	Non-PPO Network emergency services covered same as PPO network provider.

[* For more information about limitations and exceptions, see the plan or policy document at www.local467benefits.com .]

health, or substance abuse services			covered services same as PPO Network provider	
	Inpatient services	10% coinsurance of PPO rate	40% coinsurance of UCR plus any charges above UCR except for No Surprise Act covered services same as PPO Network provider.	Non-PPO Network emergency services covered same as PPO network provider.
If you are pregnant	Office visits	10% coinsurance of covered charges	40% coinsurance of UCR plus any charges above UCR	None
	Childbirth/delivery professional services	10% coinsurance of covered charges	40% coinsurance of UCR plus any charges above UCR except for No Surprise Act covered services same as PPO Network provider.	Non-PPO Network emergency services covered same as PPO network provider.
	Childbirth/delivery facility services	10% coinsurance of covered charges	40% coinsurance of UCR plus any charges above UCR except for No Surprise Act covered services same as PPO Network provider.	Non-PPO Network emergency services covered same as PPO network provider.

Common Medical Event	Services You May Need	What You Will Pay: Preferred Provider (You will pay the least)	What You Will Pay: Non-Preferred Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	10% coinsurance of covered charges	40% coinsurance of UCR plus any charges above UCR	Limited to charges for care following hospital or convalescent nursing home stay during the first 100/days or 100/visits in any 12 consecutive months.
	Rehabilitation services	10% coinsurance of covered charges	40% coinsurance of UCR plus any charges above UCR	
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	10% coinsurance of PPO rate	40% coinsurance of UCR plus any charges above UCR	Limited to care commencing within 14 days of hospital stay of at least 3 days.
	Durable medical equipment	10% coinsurance of covered charges	40% coinsurance of UCR plus any charges above UCR	None
	Hospice services	Not Covered	Not Covered	None

[* For more information about limitations and exceptions, see the plan or policy document at www.local467benefits.com .]

If your child needs dental or eye care	Children's eye exam	$15 copay/visit	Up to $45	Coverage limited to one exam/12 months. Covered up to VSP allowances. See Article IX of SPD or VSP Booklet for more details.
	Children's glasses	$15 copay/visit	Up to $45 - $105 (lenses)/ Up to $47 (frames)	Coverage limited to one set of lenses/12 months and one pair of frames/24 months. Covered up to VSP allowances. See Article IX of SPD or VSP Booklet for more details.
	Children's dental check-up	No Charge	Not Covered	$50 deductible per individual/lifetime limit. See Article VIII of SPD or Delta Dental booklet for more details.

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.)

- Bariatric Surgery
- Cosmetic Surgery (unless specifically covered under the Plan rules)
- Infertility Treatment
- Long Term Care
- Private Duty Nursing
- Weight Loss Programs (except nutritional counseling)
- Hospice Services
- Habilitation Services

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

- Acupuncture (limited to 22 visits)
- Chiropractic Care (limited to 22 visits)
- Dental Care & Orthodontic Care
- Hearing Aids (maximum $2,500 per ear over any 5 year period)
- Routine Eye Care (Adult)
- Routine Foot Care
- Non-emergency Care when traveling outside the U.S.

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: **United Administrative Service** at 1-408-288-4400 or 1-877-827-4239 or 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

[* For more information about limitations and exceptions, see the plan or policy document at www.local467benefits.com .]

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 1-408-288-4400.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-408-288-4400.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-408-288-4400.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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[* For more information about limitations and exceptions, see the plan or policy document at www.local467benefits.com .]

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	**$50**
Specialist coinsurance	**10%**
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	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$50.00
Copayments	$0.00
Coinsurance	$1280.00
What isn't covered	
Limits or exclusions	$0.00
The total Peg would pay is	**$1330.00**

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

The plan's overall deductible	**$50**
Specialist coinsurance	**10%**
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	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$50.00
Copayments	$0.00
Coinsurance	$740.00
What isn't covered	
Limits or exclusions	$0.00
The total Joe would pay is	**$790.00**

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

The plan's overall deductible	**$50**
Specialist coinsurance	**10%**
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	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$50.00
Copayments	$0.00
Coinsurance	$190.00
What isn't covered	
Limits or exclusions	$0.00
The total Mia would pay is	**$240.00**

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