Southern California Painting & Drywall Industries Plan A Coverage Period: 01/01/2019-12/31/2019

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage for: Family| Plan Type: PPO Plan**

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, contact 1-800-752-2394. 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/pdf/SBCUniformGlossary.pdf or call 1-877-572-7005 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$250 / Individual $750 / Family	You must pay all the costs up to **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st) See the chart starting on page 2 of how much you pay for covered services after you meet the **deductible**.
Are there services covered before you meet your deductible?	No	You will have to meet the **deductible** before the plan pays for any services.
Are there other deductibles for specific services?	Yes, $25 for dental benefits for dependents only. There are no other specific deductibles.	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?	$4,000 / Person	The **out-of-pocket** limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Amounts over plan maximums, premiums, balance-billed charges, and health care this plan doesn't cover	Even though you pay these expenses, they do not count towards the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. See www.anthem.com or call (800) 274-7767 for a list of participating providers	This **plan** uses a **provider network**. You will pay less if you use a **provider** in the **provider 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).
Do you need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.

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	10% coinsurance	30% coinsurance	----------none----------
	Specialist visit	10% coinsurance	30% coinsurance	----------none----------
	Preventive care/screening/ immunization	10% coinsurance	30% coinsurance	Routine physicals every 12 months. Immunizations and well baby care covered as medically necessary up to age 26.
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	----------none----------
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.[insert].com	Generic drugs	Retail $10 Mail Order $20	30% coinsurance	Must use Mail Order for all maintenance drugs.
	Preferred brand drugs	Retail $15 Mail Order $30	30% coinsurance	
	Non-preferred brand drugs	Retail $20 Mail order $40	30% coinsurance	
	Specialty drugs	Retail $10 generic, $15 brand, $20 non-formulary. Mail order- $20 generic, $30 brand, $40 non-formulary	30% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Maximums for non-contracted facilities: $2,900 in Los Angeles / Orange / San Diego $2,450 in Riverside / San Bernardino. $1,910 in San Luis Obispo / Santa Barbara / Kern. $2,340 in Ventura
	Physician/surgeon fees	10% coinsurance	30% coinsurance	----------none----------
If you need immediate medical attention	Emergency room care	10% coinsurance	30% coinsurance	----------none----------
	Emergency medical transportation	10% coinsurance	30% coinsurance	----------none----------

[* For more information about limitations and exceptions, see the plan or policy document at http://paintinganddrywalltrustfund.com/]

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)	
	Urgent care	10% coinsurance	30% coinsurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Must be pre-certified by plan or benefits could be reduced or denied if not covered
	Physician / surgeon fees	10% coinsurance	30% coinsurance	Must be pre-certified by plan or benefits could be reduced or denied if not covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	----------none----------
	Inpatient services	10% coinsurance	30% coinsurance	Must be pre-certified by plan or benefits could be reduced or denied if not covered.
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	Dependent children not covered. Only Participants and their spouses are covered.
	Childbirth / delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth / delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	$100 per day to a maximum of 60 days admission. Skilled Nursing, Home Health and Convalescent maximum is combined. If Convalescent Care is provided in a skilled nursing facility, the $100 per day maximum will not apply.
	Rehabilitation services	10% coinsurance	30% coinsurance	
	Habilitation services	Not Covered	Not Covered	----------none----------
	Skilled nursing care	10% coinsurance	30% coinsurance	Limited to 60 days admission. Skilled Nursing, Home Health and Convalescent maximum is combined.
	Durable medical equipment	10% coinsurance	30% coinsurance	Purchases in excess of $1,000 and all rentals must be pre-certified by plan or benefits could be reduced or denied if not covered.
	Hospice services	10% coinsurance	30% coinsurance	Covered for terminally ill patients with a life expectancy of six months or less.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	----------none----------
	Children's glasses	No charge	No charge	----------none----------

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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)	
	Children's dental check-up	Covered	Covered	----------none----------

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
- Non-emergency care when traveling outside the US
- Weight loss programs
- Habilitation services
- Infertility Treatment
- Private-duty nursing
- Long –term care
- Routine foot care
- Services that are not medically necessary

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

- Acupuncture, subject to payment and visit limits
- Dental care; subject to dependent deductible and calendar year maximum
- Bariatric Surgery, subject to prior authorization
- Hearing aids, up to $1,500 per Aid
- Routine eye care
- Chiropractic care, subject to visit limits

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's Employee Benefits Security Administration at (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 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: 1-800-752-2394 or Department of Labor's Employee Benefits Security Administration at (866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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.

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Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-752-2394
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-752-2394
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-752-2394
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-752-2394

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

[* For more information about limitations and exceptions, see the plan or policy document at http://paintinganddrywalltrustfund.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	$250
Specialist *[cost sharing]*	$380
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	0%

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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$33
Coinsurance	$1250
What isn't covered	
Limits or exclusions	$97
The total Peg would pay is	**$1,630**

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

The plan's overall deductible	$250
Specialist *[cost sharing]*	$95
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	0%

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	$250
Copayments	$40
Coinsurance	$95
What isn't covered	
Limits or exclusions	$294
The total Joe would pay is	**$679**

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

The plan's overall deductible	$250
Specialist *[cost sharing]*	$170
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	0%

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	$250
Copayments	$0
Coinsurance	$170
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$420**

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