This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.oetrustfunds.org** or by calling **1-800-251-5014 or 1-800-532-2105**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No. There are no other specific **deductibles**.	You don't have to meet **deductibles** for specific services but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. The **Out-of-Pocket Limit** for cost-sharing Contract providers is $6,350/person/calendar year; $12,700/family/calendar year. This Plan has a separate **Out-of-Pocket Limit** for Non-Contract Providers of $10,000/person/calendar year.	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 pay for health care expenses.
What is not included in the out–of–pocket limit?	The **Out-of-Pocket Limit** for Contract providers does not accumulate premiums, balance-billed charges, non-covered expenses, charges in excess of benefit maximums and allowed charges, dental and vision plan expenses, outpatient retail/mail order prescription drug expenses, amounts over the reference based price for certain surgeries, amounts for certain treatment at a Non-CME facility and out-of-network copayments and coinsurance.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. For a list of **Contracted providers, see www.anthem.com/ca or call 1-800-810-2583.** For a list of **Blue Card providers outside the state of California, see www.bluecares.com or call 1-800-810-2583.** For **alcoholism or chemical dependency** providers, call the **Assistance Recovery Program (ARP) at (800) 562-3277**. For **hearing aids**, call **(888) 432-7464 or (800) 442-8231**	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred** or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-800-251-5014 or 1-800-532-2105.** If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Contract **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Contract Provider	Your Cost If You Use a Non-Contract Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% co-insurance	** 20% co-insurance	Services must be medically necessary and are subject to plan limitations. In this chart, where you see "**", it means that for Non-contract providers, you pay amounts above the Plan's Allowed charge.
	Specialist visit	20% co-insurance	** 20% co-insurance	
	Other practitioner office visit	Office visits: 100% coinsurance Modalities: 20% co-insurance	Office visits: 100% coinsurance Modalities: ** 20% co-insurance	Chiropractor: maximum of 40 visits/year (combined with physical therapy). Acupuncture maximum benefit is 16 visits/treatment series. Office visits billed with modalities will be denied.
	Preventive care/screening/ immunization	No charge	Not covered except immunizations, colorectal cancer screening including colonoscopy and an annual Physical exam for Retiree and Spouse: ** 20% co-insurance. Physical Exam – No charge	Age and frequency guidelines apply to covered preventive care.
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance No charge for services billed by a Contracted free-standing lab	** 20% co-insurance	Cat Scan, MRI, Nuclear Cardiology, PET scan and echocardiography require pre-authorization by American Imaging Management if you are not Medicare eligible.
	Imaging (CT/PET scans, MRIs)			

Common Medical Event	Services You May Need	Your Cost If You Use a Contract Provider	Your Cost If You Use a Non-Contract Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available from OptumRx at www.optumrx.com or call 1-855-672-3644.	Generic drugs	Retail Pharmacy for 34-day supply: $10 copayment; Mail Order for 100-day supply: No charge. Prescription contraceptives: No charge	You pay 100% of the cost of the drug at the pharmacy and send a claim to OptumRx. Your reimbursement will be limited to the contract amount a participating pharmacy would have charged less the copayments shown for generic and brand name drugs.	For PPI drugs, you are responsible for the difference between the cost of the drug and the fixed first-dollar benefit limited to a maximum of $50 for retail or $150 for Mail order. If the cost of the drug is less than the copayment, you pay drug cost. Some drugs are subject to step therapy, quantity limits and pre-authorization. Prescription contraceptives: No charge for brand drug if generic drug is medically inappropriate.
	Brand-name drugs (if no generic is available)	Retail Pharmacy for 34-day supply: $15 copayment; Mail Order for 90-day supply: $10 copayment.		
	Brand-name drugs (if generic is available)	Retail Pharmacy for 34-day supply: $35 copayment plus difference in price between generic and brand name (unless Dr. specifies no generic substitution); Mail Order for 90-day supply: $40 copayment.		
	Specialty drugs	Generic - $10 copayment Brand-name - $15 copayment if no generic available. $35 copayment plus difference in price between generic and brand name if generic available	Not covered (except one-time exception for first purchase)	Call OptumRx at (855) 672-3644 for information on Specialty drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	** 20% co-insurance	The following limitations apply if you are not Medicare eligible: Outpatient surgery requires pre-authorization. For the hospital facility charge, a maximum of $6,000 is payable for an arthroscopy, $2,000 for cataract surgery and $1,500 for colonoscopy. A daily maximum of $500 is payable for services at a Non-Contract Ambulatory Surgery Facility.
	Physician/surgeon fees	20% co-insurance	** 20% co-insurance	Outpatient surgery requires pre-authorization if you are not Medicare eligible

Common Medical Event	Services You May Need	Your Cost If You Use a Contract Provider	Your Cost If You Use a Non-Contract Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	20% co-insurance	** 20% co-insurance	Services must be medically necessary and are subject to plan limitations
	Emergency medical transportation	20% co-insurance	** 20% co-insurance	
	Urgent care	20% co-insurance	** 20% co-insurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	** 20% co-insurance	The following limitations apply if you are not Medicare eligible: Elective hospital admission requires pre-authorization. A maximum of $30,000 is payable for the hospital facility charges associated with a single hip joint or knee joint replacement surgery.
	Physician/surgeon fee	20% co-insurance	** 20% co-insurance	Services must be medically necessary and are subject to plan limitations
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance	** 20% co-insurance	Subject to all plan limitations
	Mental/Behavioral health inpatient services	20% co-insurance	** 20% co-insurance	Elective hospital admission requires pre-authorization if you are not Medicare eligible
	Substance use disorder outpatient services	20% co-insurance	** 20% co-insurance	Subject to all plan limitations
	Substance use disorder inpatient services	20% co-insurance	** 20% co-insurance	Elective hospital admission requires precertification if you are not Medicare eligible
If you are pregnant	Prenatal and postnatal care	No charge for office visits	** 20% co-insurance	Ultrasound payable as a diagnostic test
	Delivery and all inpatient services	20% co-insurance	** 20% co-insurance	Pre-authorization required for extended hospital stay if you are not Medicare eligible. Dependent daughter's maternity inpatient confinement is not covered.

Common Medical Event	Services You May Need	Your Cost If You Use a Contract Provider	Your Cost If You Use a Non-Contract Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% co-insurance	** 20% co-insurance	Services must be medically necessary and are subject to plan limitations
	Rehabilitation services	20% co-insurance	** 20% co-insurance	Outpatient physical and occupational therapy maximum 40 visits/year (combined with Chiropractic care).
	Habilitation services	Not covered	Not covered	You pay 100% of these expenses.
	Skilled nursing care	20% co-insurance	** 20% co-insurance	Maximum of 100 days per confinement
	Durable medical equipment	20% co-insurance	** 20% co-insurance	Equipment over $500 should be approved by Anthem Blue Cross before buying/renting
	Hospice service	20% co-insurance	** 20% co-insurance	Covered if terminally ill
If your child needs dental or eye care	Eye exam	$7.50 copayment	$7.50 copayment plus any amount over $45	Covered for children under age 19
	Glasses	No charge	You are responsible for any amounts over $34 for single vision lenses and $70 for frames	Covered for children under age 19
	Dental check-up	Not covered	Not covered	Dental benefits separately insured

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Habilitation services
- Long-term care
- Private duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services
(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (up to 16 visits/treatment series)
- Bariatric Surgery (if pre-authorized as medically necessary)
- Chiropractic care (up to 40 visits per year combined with physical/occupational therapy)
- Dental care (Adult) covered through separate fully insured dental policy
- Hearing aids (100% up to $1,350/ear every 4 years)
- Infertility treatment (only services to diagnose are covered)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) covered through separate vision plan (VSP)

Your Rights to Continue Coverage:

Questions: Call **1-800-251-5014 or 1-800-532-2105.** If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform.

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at **800-251-5014.** You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Trust Fund Office at 1-800-251-5104. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-251-5104.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-251-5104.

Chinese (中文): 如果需要中文的帮助，□□□□□□□ 1-800-251-5104.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-251-5104.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,430
- **Patient pays** $1,110

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$60
Coinsurance	$1,020
Limits or exclusions	$30
Total	**$1,110**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,440
- **Patient pays** $960

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$440
Coinsurance	$480
Limits or exclusions	$40
Total	**$960**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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