Local Union 831 Employer Health Fund: Level 2

Coverage Period: 01/01/2017-12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: Individual + Family** | **Plan Type: PPO**

Plan

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 by calling 1-877.572.7005.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$ 300 / Individual, $600 / Family. Does not apply to child immunizations, prescription drugs, dental, vision, annual physical, diagnostic or preventive benefits	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 other deductibles for specific services?	Yes, $25 for dependent dental coverage only.	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.
Is there an out–of–pocket limit on my expenses?	Yes, $4,900 /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, deductibles and health care this plan does not cover.	Even though you pay these expenses, they don't count towards the **out-of-pocket limit**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.anthem.com or call 1.800.274.7767 for a list of participating providers	If you use an in-network doctor or covered health **provider**, this plan will pay a certain percentage 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 staring 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 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-877.572.7005

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf

- **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 participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amoun s.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	20% coinsurance	----------none----------
	Specialist visit	10% coinsurance	20% coinsurance	----------none----------
	Other practitioner office visit	10% coinsurance for chiropractor, physical therapy, & acupuncture	20% coinsurance for chiropractor, physical therapy, & acupuncture	Limited to 18 visits per year for any combination of these services. $100 limit for medically necessary x-rays for chiropractic in a calendar year
	Preventive care/screening/immunization	No charge	20% coinsurance	Not subject to deductible except for immunizations by participating provider for children over age 18
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	Routine lab work is not subject to deductible
	Imaging (CT/PET scans, MRIs)	10% coinsurance if with diagnosis; no charge if routine	20% coinsurance	----------none----------

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	All drugs	Retail-20% coinsurance; Mail order- 10% coinsurance	Not covered	Must use mail order for maintenance drugs; not subject to deductible. One prescription fill from a non-participating provider is allowed
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% 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	20% coinsurance	----------none----------
If you need immediate medical attention	Emergency room services	10% coinsurance	20% coinsurance	----------none----------
	Emergency medical transportation	10% coinsurance	20% coinsurance	----------none----------
	Urgent care	10% coinsurance	20% coinsurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	Must be pre-certified by plan or benefits could be reduced or denied if not covered
	Physician/surgeon fee	10% coinsurance	20% coinsurance	Must be pre-certified by plan or benefits could be reduced or denied if not covered
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance	20% coinsurance	----------none----------
	Mental/Behavioral health inpatient services	10% coinsurance	20% coinsurance	Must be pre-certified by plan or benefits could be reduced or denied if not covered

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Substance use disorder outpatient services	10% coinsurance	20% coinsurance	----------none----------
	Substance use disorder inpatient services	10% coinsurance	20% coinsurance	Must be pre-certified by plan or benefits could be reduced or denied if not covered
If you are pregnant	Prenatal and postnatal care	10% coinsurance	20% coinsurance	Children not covered. Only participants and their spouses are covered.
	Delivery and all inpatient services	10% coinsurance	20% coinsurance	----------none----------
If you need help recovering or have other special health needs	Home health care	10% coinsurance	50% coinsurance	Limited to 60 days per calendar year in total for these services and skilled nursing care; must be pre-certified by plan or benefits could be reduced or denied if not covered
	Rehabilitation services	10% coinsurance	50% coinsurance	
	Habilitation services	Not covered	Not covered	----------none----------
	Skilled nursing care	10% coinsurance	50% coinsurance	Limited to 60 days per calendar year in total for these services together with home health care and rehabilitation services; must be pre-certified by plan or benefits could be reduced or denied if not covered
	Durable medical equipment	10% coinsurance	20% coinsurance	Purchases in excess of $500 and all rentals must be pre-certified by plan or benefits could be reduced or denied if not covered
	Hospice service	10% coinsurance	20% coinsurance	Must be pre-certified by plan or benefits could be reduced or denied if not covered
If your child needs dental or eye care	Eye exam	No charge	No charge	Not subject to deductible
	Glasses	No charge	No charge	Not subject to deductible
	Dental check-up	30% coinsurance	30% coinsurance	$25 deductible for dependents only.

xcluded 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
- Infertility Treatment
- Long –term care
- Non-emergency care when traveling outside the US
- Routine foot care
- Services that are not medically necessary
- 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, subject to payment and visit limits
- Bariatric Surgery, subject to prior authorization
- Chiropractic care, subject to payment and visit limits
- Dental care (Adult), subject to dependent deductible and calendar year maximum
- Hearing aids, limited to $800 per ear
- Private-duty nursing
- Routine eye care (Adult)

Your Rights to Continue Coverage: If you lose coverage under the Plan, 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 Trust Fund Office at 1.877.572.7005. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1.866.444.383 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1.877.267.2323 X61565 or www.cciio.cms.gov

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 1.877.572.7005 or the Department of Labor's Employee Benefits Security Administration at 1.8666-444-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 standards 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 1.877.572.7005

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** $6,590
- **Patient pays** $ 950

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	$300
Copays	$0
Coinsurance	$650
Limits or exclusions	$0
Total	**$950**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,600
- **Patient pays** $ 800

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	$300
Copays	$290
Coinsurance	$210
Limits or exclusions	$0
Total	**$800**

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.