



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.ironworkerbenny.com or by calling the Trust Fund Office at 1-800-527-4613.

Important Questions	Answers	Why this Matters:
<p>What is the overall <u>deductible</u>?</p>	<p>For Contract Providers: \$250 person / \$500 family; does not apply to physician office visits, preventive care, prescription drugs, x-ray & lab, chiropractic and acupuncture, outpatient therapy, outpatient mental health and substance abuse, emergency ground ambulance, urgent care, physician home visits, exams for podiatry, hearing exams, hearing aids, hospice care, prescription drug, and excluded services.</p> <p>For Non-Contract Providers: \$500 person / \$1,500 family; deductible applies to most services. Does not apply to balance billed amounts, emergency ground ambulance, hearing exams, hearing aids, hospice care, supplemental accident, and excluded services.</p>	<p>You must pay all the costs up to the <u>deductible</u> amount before this Plan begins to pay for covered services you use. Check your policy or Plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u>.</p>
<p>Are there other <u>deductibles</u> for specific services?</p>	<p>Yes. \$50 person/\$150 family for Fee-for-Service PPO Dental Plan. There are no other specific <u>deductibles</u>.</p>	<p>You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this Plan begins to pay for these services.</p>
<p>Is there an <u>out-of-pocket limit</u> on my expenses?</p>	<p>Yes, for Contract Providers: \$2,000 person/\$4,000 family. For Non-Contract Providers there is no out-of-pocket limit.</p>	<p>The <u>out-of-pocket limit</u> 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.</p>
<p>What is not included in the <u>out-of-pocket limit</u>?</p>	<p>Expenses you pay for skilled nursing facility, non-covered services (i.e. excluded services), charges in excess of benefit maximums, charges for services from Non-Contract Providers, and expenses you pay for vision care, prescription drugs, dental care, and orthodontia.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>
<p>Is there an overall annual limit on what the Plan pays?</p>	<p>\$5,000,000 until May 31, 2014, thereafter no maximum.</p>	<p>This Plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes <i>specific</i> coverage limits, such as limits on the number of office visits.</p>

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<p>Does this Plan use a network of providers?</p>	<p>Yes. For a list of Contract Providers, go to www.anthem.com/ca for medical providers; and www.MHN.com for mental health and substance abuse providers. You may also contact the Fund Office at 800-527-4613.</p>	<p>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.</p>
<p>Do I need a referral to see a specialist?</p>	<p>No</p>	<p>You can see the specialist you choose without permission from this Plan.</p>
<p>Are there services this Plan doesn't cover?</p>	<p>Yes</p>	<p>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.</p>



- **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
<p>If you visit a health care provider's office or clinic</p>	<p>Primary care visit to treat an injury or illness</p>	<p>Premier Plan: \$20 per visit; Basic Plan: \$50 per visit; deductible does not apply</p>	<p>40% coinsurance</p>	<p>---none---</p>
	<p>Specialist visit</p>	<p>Premier Plan: \$20 per visit; Basic Plan: \$50 per visit; deductible does not apply</p>	<p>40% coinsurance</p>	<p>---none---</p>

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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
	Other practitioner office visit	For chiropractor and acupuncture: Premier Plan: \$20 per visit; Basic Plan: \$50 per visit; deductible does not apply	For chiropractor and acupuncture: 40% coinsurance	Plan payments for acupuncture and chiropractic coverage are limited to a combined max of \$2,000 per calendar year. For outpatient therapy: see "If you need help recovering or have other special health needs" below.
	Preventive care/screening/Immunization	No charge	40% coinsurance	Plan covers preventive services and supplies required to be covered by health care reform law (age and frequency limits apply).
If you have a test	Diagnostic test (x-ray, blood work)	Premier Plan: \$20 per visit; Basic Plan: \$50 per visit; deductible does not apply	40% coinsurance	<i>Preauthorization by PHA</i> is required if obtained outside of your physician's office. Failure to obtain preauthorization will result in you paying an additional 10% coinsurance.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	40% coinsurance	<i>Preauthorization by PHA</i> is required or you will pay an additional 10% coinsurance.

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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
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available from EnvisionRx at www.envision.com or call 1-800-361-4542.</p>	<p>Generic drugs</p>	<p><i>Retail (per prescription):</i> Premier Plan: \$10 copayment Basic Plan: \$15 copayment</p> <p><i>Mail order (per prescription):</i> Premier Plan: \$20 copayment Basic Plan: \$30 copayment; Deductible does not apply</p>	<p>100% coinsurance (retail & mail order); limited exceptions for emergency prescriptions</p>	<p>Limited to a 30-day supply at retail and a 90-day supply for mail-order. Mail order is mandatory for maintenance medication. After the 3rd refill at retail, you will be charged 2 copayments.</p>
	<p>Formulary brand drugs</p>	<p><i>Retail (per prescription):</i> Premier Plan: \$20 copayment Basic Plan: \$35 copayment</p> <p><i>Mail order (per prescription):</i> Premier Plan: \$40 copayment Basic Plan: \$70 copayment; Deductible does not apply</p>	<p>Not covered; limited exceptions for emergency prescriptions</p>	<p>Limited to a 30-day supply at retail and a 90-day supply for mail-order. Mail order is mandatory for maintenance medication. After the 3rd refill at retail, you will be charged 2 copayments.</p>
	<p>Non-formulary brand or generic drugs</p>	<p>Not covered unless preauthorization is obtained. If preauthorized, paid as a formulary drug.</p>	<p>Not covered; limited exceptions for emergency prescriptions</p>	<p>You pay 100% of the cost of the non-formulary drug if you do not obtain preauthorization.</p>

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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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	100% coinsurance for charges above the Plan's maximum payment of \$350 per day in the facility	<i>Preauthorization by PHA</i> required for all outpatient surgeries or you will pay an additional 10% coinsurance. Certain procedures have a maximum allowable charge (MAC) if performed in a California facility. You can be balance billed for charges above the MAC. If you use a Contract Provider, MAC for arthroscopies is \$6,000; MAC for cataract surgery is \$2,000; MAC for Colonoscopy is \$1,500. Maximum benefit of \$350 per day for services from Non-Contract providers (the \$350 limit also applies to MAC procedures). Bariatric Surgeries covered only if performed at a Blue Distinction Center for Bariatric Surgery.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	<i>Preauthorization by PHA</i> is required or you will pay an additional 10% coinsurance.
If you need immediate medical attention	Emergency room services	10% coinsurance	10% coinsurance	Limited to services for emergency medical conditions.
	Emergency medical transportation	\$50 co-payment for ground ambulance; deductible does not apply	\$50 co-payment for ground ambulance; deductible does not apply	-- None --
	Urgent care	Premier Plan: \$20 per visit; Basic Plan: \$50 per visit; deductible does not apply	40% coinsurance	-- None --

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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 have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	<i>Must be pre-certified by</i> Anthem or you will pay an additional 10% coinsurance. Total hip or total knee procedures have a maximum allowable charge (MAC) if performed in a California facility. MAC for hip or knee procedures is \$30,000.
	Physician/surgeon fee	10% coinsurance	40% coinsurance	<i>Must be pre-certified by Anthem</i> or you will pay an additional 10% coinsurance.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Premier Plan: \$20 per visit; Basic Plan: \$50 per visit; deductible does not apply	40% coinsurance	–None–
	Mental/Behavioral health inpatient services	10% coinsurance	40% coinsurance	<i>Must be preauthorized by MHN</i> or you will pay an additional 10% coinsurance.
	Substance use disorder outpatient services	Premier Plan: \$20 per visit; Basic Plan: \$50 per visit; deductible does not apply	40% coinsurance	No Dependent coverage.
	Substance use disorder inpatient services	10% coinsurance	40% coinsurance	<i>Must be preauthorized by MHN</i> or you will pay an additional 10% coinsurance. No Dependent coverage.
If you are pregnant	Prenatal and postnatal care	Premier Plan: \$20 per visit; Basic Plan: \$50 per visit; deductible does not apply	40% coinsurance	Ultrasound covered as a diagnostic test; Preventive Care covered at 100% if you use a Contract Provider.
	Delivery and all inpatient services	10% coinsurance	40% coinsurance	<i>Pre-certification by Anthem</i> is required for extended stays.

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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-payment/visit plus 10% coinsurance	40% coinsurance	-- None --
	Rehabilitation services	Premier Plan: \$20 per visit; Basic Plan: \$50 per visit; deductible does not apply	40% coinsurance	<i>Preauthorization by PHA required</i> for all outpatient therapy or you will pay an additional 10% coinsurance. Speech and occupational therapies are limited to a combined maximum of 20 visits per calendar year; physical and respiratory therapies are limited to a combined maximum of 20 visits per calendar year
	Habilitation services	Not covered	Not covered	--None--
	Skilled nursing care	Skilled Nursing facility: 55% coinsurance. If nursing care billed separately: paid as Home health care	Skilled Nursing facility: 65% coinsurance. If nursing care billed separately: paid as Home health care	Plan payments are limited to 55 days per disability. Admission to Skilled Nursing facility must follow a minimum 5-day hospital stay and must be within 7 days of hospital discharge. Not subject to out-of-pocket limit.
	Durable medical equipment	20% coinsurance	40% coinsurance	<i>Preauthorization by PHA</i> is required for durable medical equipment costing over \$500 or you will pay an additional 10% coinsurance.
	Hospice service	No charge	No charge	Coverage for patients with less than a 6-month life expectancy.
If your child needs dental or eye care	Eye exam	VSP: \$25 co-payment; Spectera: \$10 co-payment; deductible does not apply	100% coinsurance on charges above the VSP or Spectera allowed amount; deductible does not apply	You must enroll in VSP or Spectera to have coverage. Exam limited to once every 12 months.

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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
	Glasses	VSP: 100% of charges over the Plan allowance for frames. Spectera: \$10 co-payment plus 100% of charges over the Plan allowance for frames; deductible does not apply	100% coinsurance for charges above VSP or Spectera out-of-network allowed amounts (you will pay more if you do not use a participating provider); deductible does not apply).	You must enroll in Spectera or VSP to have coverage. VSP: glasses (or contacts) allowed once every 12 months; allowance for frames (or contacts) is \$150; Spectera: frames allowed once every 24 months, lenses allowed once every 12 months; allowance for frames is \$130 (\$105 for contacts).
	Dental check-up	Fee-for-Service Dental Plan: no charge after \$50 dental deductible. For Dental HMO plans see Open Enrollment Plan Comparison.	Fee-for-Service Dental Plan: 20% coinsurance after \$50 dental deductible. For Dental HMO plans see Open Enrollment Plan Comparison.	Benefits are available through a contract with Delta Dental. Alternatively, you can enroll in one of the Plan's dental HMO plans.

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 <u>excluded services</u>.)		
<ul style="list-style-type: none"> • Cosmetic surgery • Habilitation services 	<ul style="list-style-type: none"> • Infertility treatment • Long-term care • Non-emergency care when traveling outside U.S. 	<ul style="list-style-type: none"> • Weight loss programs (except limited coverage for counseling services for obesity)

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.)		
<ul style="list-style-type: none"> • Acupuncture (subject to annual limits) • Bariatric surgery (preauthorization required; covered only if surgery performed at an Anthem Blue Distinction facility) • Chiropractic care (subject to annual limits) 	<ul style="list-style-type: none"> • Dental care (Adult) (Limitations apply depending on dental Plan) • Hearing aids (allowed amount of \$2,000 per device; once every 3 years) • Private-duty nursing (Must be medically necessary) 	<ul style="list-style-type: none"> • Routine eye care (Adult) (Limitations apply depending on vision Plan) • Routine foot care (Orthotic appliances limited to a \$200 maximum per calendar year. Coverage for contract providers only.)

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Your Rights to Continue Coverage:

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 1-800-527-4613. 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, 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 1-800-527-4613. 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 the 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 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 1-800-527-4613.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-527-4613.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-527-4613.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-800-527-4613.

—————*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 Premier:** \$6,690, **Basic:** \$6,580
- **Patient pays Premier:** \$850; **Basic:** \$960

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:

	Premier	Basic
Deductibles	\$250	\$250
Copayments	\$150	\$260
Coinsurance	\$420	\$420
Limits or exclusions	\$30	\$30
Total	\$850	\$960

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

- **Amount owed to Providers:** \$5,400
- **Plan pays Premier:** \$4,230, **Basic:** \$3,680
- **Patient pays Premier:** \$1,170, **Basic:** \$1,720

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:

	Premier	Basic
Deductibles	\$250	\$250
Copayments	\$680	\$1,230
Coinsurance	\$200	\$200
Limits or exclusions	\$400	\$400
Total	\$1,170	\$1,720

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.