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:
What is the overall deductible?	For Contract Providers: **$500** person / **$1,500** family; Does not apply to preventive care, prescription drugs, chiropractic and acupuncture, outpatient therapy, exams for podiatry, hearing exams, hearing aids, hospice care, office visit for allergy care, and excluded services. For Non-Contract Providers: **$750** person / **$2,250** family; does not apply to balance billed amounts, hearing exams, hearing aids, hospice care, and excluded services.	You must pay all the costs up to the **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 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$50** person/**$150** family for Fee-for-Service PPO Dental Plan. 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.
Is there an out-of-pocket limit on my expenses?	Yes, for Contract Providers: **$1,000** person/**$3,000** family. For Non-Contract Providers there is no out-of-pocket limit.	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?	Premiums, balance billed charges, health care this Plan doesn't cover, expenses you pay for skilled nursing facility, non-covered services (i.e. excluded services), and for services from Non-Contract Providers.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the Plan pays?	Yes, $2 million until May 31, 2014, thereafter no maximum.	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 *specific* coverage limits, such as limits on the number of office visits.
Does this Plan use a network of providers?	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.	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**.

- **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	Premier: 20% coinsurance Basic: 30% coinsurance	40% coinsurance	---none---
	Specialist visit	Premier: 20% coinsurance Basic: 30% coinsurance	40% coinsurance	---none---
	Other practitioner office visit	Premier 100% after $20 copayment Basic: 100% after $50 copayment, Applicable to chiropractor, acupuncture, allergy care, and podiatry; deductible does not apply	40% coinsurance for chiropractor, acupuncture, and podiatry	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.

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
	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: 20% coinsurance Basic: 30% coinsurance	40% coinsurance	***Preauthorization by PHA*** is required if obtained outside of your physician's office. Failure to obtain preauthorization will result in additional 10% coinsurance.
	Imaging (CT/PET scans, MRIs)	Premier: 20% coinsurance Basic: 30% coinsurance	40% coinsurance	***Preauthorization by PHA*** is required. Failure to obtain preauthorization will result in additional 10% coinsurance.
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available from EnvisionRx at www.envision.com or call 1-800-361-4542.**	Generic drugs	Premier: $10 copayment Basic: $15 copayment; deductible does not apply	Not covered; limited exceptions for emergency prescriptions	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.
	Formulary brand drugs	Premier: $20 copayment Basic: $35 copayment; deductible does not apply	Not covered; limited exceptions for emergency prescriptions	
	Non-formulary brand or generic drugs	Not covered unless preauthorization is obtained. If preauthorized, paid as a formulary drug	Not covered; limited exceptions for emergency prescriptions	You pay 100% of the cost of the non-formulary drug if you do not obtain preauthorization.

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)	Premier: 20% coinsurance Basic: 30% coinsurance	100% coinsurance for charges above the Plan's maximum payment of $350 per day in the facility	***Preauthorization by PHA*** required for all outpatient surgeries. Failure to obtain preauthorization results in additional 10% coinsurance. Arthroscopies, cataract surgeries, and colonoscopies are subject to a maximum allowable charge (MAC). You can be balance billed for charges above the MAC. Bariatric Surgeries are covered only if performed at a Blue Distinction Center for Bariatric Surgery. The Plan's benefit for all Non-Contract providers is limited to $350 per day that you are a patient in the facility (this $350 limit also applies to MAC procedures performed at non-contract facilities).
	Physician/surgeon fees	Premier: 20% coinsurance Basic: 30% coinsurance	40% coinsurance	***Preauthorization by PHA*** is required. Failure to obtain preauthorization will result in additional 10% coinsurance.
If you need immediate medical attention	Emergency room services	Premier: 20% coinsurance Basic: 30% coinsurance	Premier: 20% coinsurance Basic: 30% coinsurance	Limited to services for emergency medical conditions.
	Emergency medical transportation	Premier: 20% coinsurance Basic: 30% coinsurance	Premier: 20% coinsurance Basic: 30% coinsurance	-- None --
	Urgent care	Premier: 20% coinsurance Basic: 30% coinsurance	40% coinsurance	-- None --
If you have a hospital stay	Facility fee (e.g., hospital room)	Premier: 20% coinsurance Basic: 30% coinsurance	40% coinsurance	***Must be Pre-certified by Anthem.*** Failure to obtain pre-certification will result in additional 10% coinsurance.
	Physician/surgeon fee	Premier: 20% coinsurance Basic: 30% coinsurance	40% coinsurance	Pre-certification by Anthem is required. Failure to obtain pre-certification will result in additional 10% coinsurance.

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 mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Premier: 20% coinsurance Basic: 30% coinsurance	40% coinsurance	–None--
	Mental/Behavioral health inpatient services	Premier: 20% coinsurance Basic: 30% coinsurance	40% coinsurance	***Must be preauthorized by MHN*** or you will pay an additional 10% coinsurance.
	Substance use disorder outpatient services	Premier: 20% coinsurance Basic: 30% coinsurance	40% coinsurance	**No Dependent coverage.**
	Substance use disorder inpatient services	Premier: 20% coinsurance Basic: 30% coinsurance	40% coinsurance	***Preauthorization by MHN*** is required or you will pay an additional 10% coinsurance. **No Dependent coverage.**
If you are pregnant	Prenatal and postnatal care	Premier: 20% coinsurance Basic: 30% coinsurance	40% coinsurance	Ultrasound covered as a diagnostic test. Preventive care covered at 100% if you use a Contract Provider.
	Delivery and all inpatient services	Premier: 20% coinsurance Basic: 30% coinsurance	40% coinsurance	Pre-certification by Anthem is required for extended stays.
If you need help recovering or have other special health needs	Home health care	Premier: 20% coinsurance Basic: 30% coinsurance	40% coinsurance	-- None --
	Rehabilitation services	Premier: 100% after $20 copayment Basic: 100% after $50 copayment	40% coinsurance	Preauthorization required for all outpatient therapy. Failure to obtain preauthorization will result in 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--

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
	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	Premier: 20% coinsurance Basic: 30% coinsurance	40% coinsurance	***Preauthorization by PHA*** is required for durable medical equipment costs over $500. Failure to obtain preauthorization will result in 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.
	Glasses	VSP: 100% of charges over the Plan allowance for frames (or contacts). Spectera: $10 co-payment plus 100% of charges over the Plan allowance for frames (or contacts); deductible does not apply	100% coinsurance for charges above VSP or Spectera allowed amounts for out-of-network providers (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 PPO Plan: no charge after $50 dental deductible. For Dental HMO plans see Open Enrollment Plan Comparison.	Fee-for-Service Dental PPO 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 excluded services.)

- Cosmetic surgery
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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.)

- Acupuncture (Limited to a combined calendar year maximum with chiropractic benefits of $2,000)
- Bariatric surgery (preauthorization required; covered only if surgery performed at an Anthem Blue Distinction facility)
- Chiropractic care (Limited to a combined calendar year maximum with acupuncture benefits of $2,000)
- 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)
- Routine eye care (Adult) (Limitations apply)
- Routine foot care (Limitations apply)

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.

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 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.**

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.

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, kwiijigo 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: $6,450, Basic: $6,430
- **Patient pays** Premier: $1,090, Basic: $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:

	Premier	Basic
Deductibles	$500	$500
Copayments	$60	$80
Coinsurance	$500	$500
Limits or exclusions	$30	$30
Total	**$1,090**	**$1,110**

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

- **Amount owed to Providers:** $5,400
- **Plan pays** Premier: $3,800, Basic: $3,440
- **Patient pays** Premier: $1,600, Basic: $1,960

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:

	Premier	Basic
Deductibles	$500	$500
Copayments	$440	$640
Coinsurance	$330	$490
Limits or exclusions	$330	$330
Total	**$1,600**	**$1,960**

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.