Operating Engineers Health and Welfare Trust Fund

Coverage Period: 01/01/2014 – 12/31/2014

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

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.oe3trustfunds.org** or by calling **1-800-251-5014 or 1-800-532-2105.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network PPO Provider: **$500**/person; **$1,500**/family Does not apply to Contract provider preventive care, the hearing aid benefit and outpatient prescription drugs. Copayments and a penalty for failure to obtain pre-authorization do not count toward the **deductible**.	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, $100** for retail brand name drugs (except for brand name PPI drugs). 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, Contract Provider: **$5,000**/person; **$12,700**/family Non-Contract Provider: **$10,000**/person; **$30,000**/family	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 services does not accumulate these: 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 Contract providers**, use the Provider Finder feature on **www.anthem.com/ca** or call the Trust Fund Office at (800) 251-5014. **For a list of Contract providers outside of California,** see **www.bluecares.com** or call 1-800-810-2583. For **chemical dependency providers**, call 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 N**etwork**. 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.

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.

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 Out-of-Area Provider	Your Cost If You Use 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	10% co-insurance	10% 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	10% co-insurance	10% co-insurance	** 20% co-insurance	
	Other practitioner office visit	Office visits: 100% coinsurance Modalities: 10% co-insurance	Office visits: 100% coinsurance Modalities: 10% co-insurance	Office visits: 100% coinsurance Modalities: ** 20% co-insurance	Chiropractor: maximum benefit is 20 visits/year. Acupuncture: max benefit is 16 visits/treatment series. Office visits billed with modalities will be denied.
	Preventive care/screening/immuni-zation	No charge	No charge for physical exam (employee/spouse). 10% co-insurance for mammogram, Pap smear, colorectal cancer screening, immunizations	No charge for physical exam (employee/spouse). ** 20% co-insurance for mammogram, Pap smear, colorectal cancer screening, immunizations	Plan covers preventive services and supplies required by the Health Reform law. Age and frequency guidelines apply to covered preventive care

If you have a test	Diagnostic test (x-ray, blood work)	10% co-insurance	10% co-insurance	** 20% co-insurance	Imaging tests require pre-authorization by American Imaging Management
	Imaging (CT/PET scans, MRIs)	10% co-insurance	10% co-insurance	** 20% co-insurance	
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: $5 copayment (34-day supply). Mail Order: $10 copayment (90-day supply). Prescription contraceptives: No charge	You pay the participating pharmacy copayments + any amount the pharmacy charges above the contract amount the participating pharmacy would have charged.		Maximum payment of $30 for retail PPI drugs ($90 mail order). If you obtain a brand drug at a Retail Pharmacy when a generic drug is available, you pay the brand copay + the cost difference between the brand and generic drug (unless Dr. specifies no generic substitution). If the cost of the drug is less than the copayment, you pay just the 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.
	Preferred Brand name drugs	Retail Pharmacy: $25 copayment (34-day supply). Mail Order: $50 copayment (90-day supply).			
	Non-preferred brand name drugs	Retail Pharmacy: $40 copayment (34-day supply). Mail Order: $80 copayment (90-day supply)			
	Specialty drugs	Retail copays apply	Not covered (except for a one-time exception for the first purchase of a Specialty drug)		Available only through OptumRx Specialty Drug Program
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-insurance	10% co-insurance	** 20% co-insurance (+ amount over contract rate if not an emergency medical condition)	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	10% co-insurance	10% co-insurance	** 20% co-insurance	

If you need immediate medical attention	Emergency room services	10% co-insurance + a $100 copayment/visit	10% co-insurance + a $100 copayment/visit	** 20% co-insurance + a $100 copayment/visit (+ amount over contract rate if not emergency medical condition)	Copay waived if you are admitted to the hospital.
	Emergency medical transportation	10% co-insurance	10% co-insurance	** 20% co-insurance	Services must be medically necessary and are subject to plan limitations.
	Urgent care	10% co-insurance	10% co-insurance	** 20% co-insurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance	10% co-insurance	** 20% co-insurance(+ amount over contract rate if not an emergency medical condition)	Elective hospital admit requires pre-authorization. A $30,000 max is payable for hospital facility charges associated with a single hip joint or knee joint replacement surgery.
	Physician/surgeon fee	10% co-insurance	10% co-insurance	** 20% co-insurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% co-insurance	10% co-insurance	** 20% co-insurance (+ amount over contract rate if not an emergency medical condition)	Services must be medically necessary and are subject to plan limitations.
	Mental/Behavioral health inpatient services	10% co-insurance	10% co-insurance	** 20% co-insurance	Elective hospital admission requires pre-authorization
	Substance use disorder outpatient services	10% co-insurance	10% co-insurance	** 20% co-insurance	Services must be medically necessary and are subject to plan limitations.
	Substance use disorder inpatient services	10% co-insurance	10% co-insurance	** 20% co-insurance	Pre-authorization required if elective
If you are pregnant	Prenatal and postnatal care	No charge for many services necessary for prenatal care.	10% co-insurance	** 20% co-insurance	Ultrasound payable as a diagnostic test
	Delivery and all inpatient services	10% co-insurance	10% co-insurance	** 20% co-insurance (+ amount over contract rate if not an emergency medical condition)	Pre-authorization required for extended hospital stay. Pregnancy for dependent child not covered.

If you need help recovering or have other special health needs	Home health care	10% co-insurance	10% co-insurance	** 20% co-insurance	Services must be medically necessary and are subject to plan limitations.
	Rehabilitation services	10% co-insurance	10% co-insurance	** 20% co-insurance	Outpatient physical, & occupational therapy max benefit is 20 visits/year (40 if 24 months before/after related surgery or stroke)
	Habilitation services	Not covered	Not covered	Not covered	You pay 100% of these expenses
	Skilled nursing care	10% co-insurance	10% co-insurance	** 20% co-insurance	Pre-authorization required
	Durable medical equipment	10% co-insurance	10% co-insurance	** 20% co-insurance	Pre-authorization recommended for equipment over $500
	Hospice service	10% co-insurance	10% co-insurance	** 20% co-insurance	Covered if terminally ill
If your child needs dental or eye care	Eye exam	$7.50 copay	$7.50 copay + any amount over $37	$7.50 copay + any amount over $37	Limitations on frequency do not apply to children under age 19
	Glasses	No charge for single vision lenses. You pay any amount over $170 for frames.	You are responsible for any amounts over $34 for single vision lenses and $40 for frame	You are responsible for any amounts over $34 for single vision lenses and $40 for frame	
	Dental check-up	Not covered	Not covered	Not covered	Dental benefits are 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 20 visits per year).
- Dental care (Adult) through separate insured Delta Dental policy up to $2,500/calendar year
- 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)under separate vision plan (VSP)

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 (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, 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 1-800-251-5014. 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 1-800-251-5014.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-251-5014.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-251-5014.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-251-5014.

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** $6,520
- **Patient pays** $1,020

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	$500
Copays	$30
Coinsurance	$460
Limits or exclusions	$30
Total	**$1,020**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,430
- **Patient pays** $970

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	$500
Copays	$240
Coinsurance	$190
Limits or exclusions	$40
Total	**$970**

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.

5273879v1/00580.001