Los Angeles Machinist Benefit Trust: PPO High Option A

Coverage Period: 01/01/2013 – 12/31/2013

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: 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 summary plan description or plan document at www.lambt.org or by calling 1-800-499-8121.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$100** person **/$200** family. Unused amount for deductible in last quarter can be used to satisfy next year's 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?	No. 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 PPO providers **$500** per person. **No** out-of-pocket limit for non-PPO providers.	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?	Premiums, balance-billed charges, and health care this plan doesn't cover.	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, **$2,000,000** per person.	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/ca or call **1 (323) 278-7030** or **1 (800) 499-8121** for a list of participating providers (PPO).	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 terms in-network, **preferred,** or participating **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 don't need a referral to see a specialist.	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 4. See your summary plan description or plan document for additional information about **excluded services**.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** 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 in-network PPO **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	20% coinsurance	After deductible (20% based on UCR)
	Specialist visit	No charge	20% coinsurance	After deductible (20% based on UCR)
	Other practitioner office visit	No charge	20% coinsurance	After deductible (20% based on UCR)
	Preventive care/screening/immunization	No charge	20% coinsurance	After the 1st $500/adult or $200/child
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	After deductible (20% based on UCR)
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	After deductible (20% based on UCR)
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.procarerx.com.	Generic drugs	$2 copay per prescription	$2 copay per prescription	Maximum day supply – 30-day retail; 60-day mail
	Preferred brand drugs	$2 copay per prescription	$2 copay per prescription	Preferred and non-preferred brand drugs are only covered when medically necessary or a generic is not available. If brand is chosen instead, copay is difference in cost between generic and brand.
	Non-preferred brand drugs	$2 copay per prescription	$2 copay per prescription	
	Specialty drugs	$2 copay per prescription	$2 copay per prescription	Prior authorization required – 30-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	After deductible (20% based on UCR)
	Physician/surgeon fees	No charge	20% coinsurance	After deductible (20% based on UCR)

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	20% of allowable	20% coinsurance	After 1st $500 per visit
	Emergency medical transportation	20% of allowable	20% coinsurance	After deductible (20% based on UCR)
	Urgent care	No charge	20% coinsurance	After deductible (20% based on UCR)
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	After deductible (20% based on UCR)
	Physician/surgeon fee	No charge	20% coinsurance	After deductible (20% based on UCR)
If you have mental health, behavioral health, or substance abuse needs. For help, contact www.mhn.com or 1-(800) 327-7701 for	Mental/Behavioral health outpatient services	No charge	20% coinsurance	After deductible (20% based on UCR)
	Mental/Behavioral health inpatient services, Intensive Outpatient, Partial Hospitalization and Residential	No charge	20% coinsurance	After deductible (20% based on UCR)
	Substance use disorder outpatient services	No charge	20% coinsurance	After deductible (20% based on UCR)
	Substance use disorder inpatient services	No charge	20% coinsurance	After deductible (20% based on UCR)
If you are pregnant	Prenatal and postnatal care	No charge	20% coinsurance	After deductible (20% based on UCR)
	Delivery and all inpatient services	No charge	20% coinsurance	After deductible (20% based on UCR)
If you need help recovering or have other special health needs	Home health care	20% of allowable	20% coinsurance	30 days/calendar year; After deductible
	Rehabilitation services	No charge	20% coinsurance	After deductible; 13 visits combined – rehab, acupuncture, chiropractic, physical, speech, respiratory and vision therapy
	Habilitation services	Not covered	Not covered	Not considered medically necessary
	Skilled nursing care	$20 payment/day	20% coinsurance	After deductible 30 day limit maximum
	Durable medical equipment	20% of allowable	20% coinsurance	After deductible (20% based on UCR)
	Hospice service	No charge	20% coinsurance	After deductible - 30 day maximum
If your child needs dental or eye care	Eye exam	$5 copay	Up to $50	Limited to one exam and lenses per year; out-of-network benefits scheduled
	Glasses	No charge	Up to $300	Limited to 1 frame every 2 years; out of network vision benefits - scheduled

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
	Dental check-up	No charge	20% coinsurance	Up to $2,500 per year for all dental services to age 19 – indemnity dental plan; scheduled copays in the prepaid dental plan.

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.)

- Treatment that is not medically necessary
- Any type of artificial insemination
- Adult vision and dental services
- Weight control programs
- Cosmetic surgery
- Genetic counseling
- Non-PPO substance abuse and mental health services

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.)

- Refer to MHN for Employee Assistance Program details MHN 1-(800) 327-7701
- Refer to Vision Service Plan (VSP) 1- (800) 877-7195; and, Medical Eye Service (MES) 1 (800) 638-3120
- Refer to Dental Plans through United Concordia for prepaid and indemnity dental coverage 1- (866) 357-3304

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 high 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) 499-8121. 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) 0267-2323 x 61565 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 Plan administrative office at 1 (800) 499-8121 or the Department of Labor's Employee Benefits Security Administration at 1 (866) 444-EBSA (3272) or www.dol.gov.ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the California Department of Managed Health Care Help Center, 980 9th St, Suite 500, Sacramento, CA 9584 at 1 (888) 466-2219 or on the web at www.healthhelp.ca.gov or by email at helpline@dmhc.ca.gov.

Language Access Services:

Written translations are available in the following language within 7 business days by contracting plan representatives at the phone number below:

Spanish (Espanol): Para obtener asistencia en Espanol, llame al 1-(800) 533-0119.

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 $7,438**
- **Patient pays $ 102**

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	$100
Co-pays	$2
Co-insurance	$0
Limits or exclusions	$0
Total	**$102**

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

- **Amount owed to providers: $4,100**
- **Plan pays $3,738**
- **Patient pays $362**

Sample care costs:

Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$4,100**

Patient pays:

Deductibles	$100
Co-pays	$2
Co-insurance	$260
Limits or exclusions	$0
Total	**$362**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.