**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?** | 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/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**. |



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; 6 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.

## 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 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.**

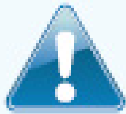
## Language Access Services:

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 Español, 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 | $0 |
| Co-insurance | $0 |
| Limits or exclusions | $150 |
| **Total** | **$250** |

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

- **Amount owed to providers: $5,400**
- **Plan pays $4,910**
- **Patient pays $490**

**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 | $100 |
| Co-pays | $80 |
| Co-insurance | $230 |
| Limits or exclusions | $80 |
| **Total** | **$490** |

# 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.