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.aitrustfunds.org** or by calling **1-800-635-3105**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	PPO (In-Network) and Non-PPO (Out-of-Network) combined: **$500**/person; **$1,500**/family. Does not apply to outpatient prescription drugs, LiveHealth online visit and PPO preventive care. Balance billing, excluded services and penalties for not complying with preauthorization requirements 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?	**No**	You don't have to meet **deductibles** for specific services but see the chart starting on page 2 for other costs for services this Plan covers.
Is there an out-of-pocket limit on my expenses?	Yes, for the medical plan, the **Out-of-Pocket limit** for PPO deductibles, copays, and coinsurance per calendar year is **$1,500/person; $4,400/family of 3 or more**. The **Out-of-Pocket Limit on outpatient drugs** is the most you pay for covered in-network prescription drugs is **$1,500/person; $4,400/family** of 3 or more. These amounts may be adjusted in accordance with law.	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 PPO deductibles, copays and coinsurance and the **Out-of-Pocket Limit** for in-network prescription drugs do not include premiums, balance-billed charges, healthcare this plan does not cover, charges in excess of benefit maximums and allowed charges, amounts for a brand drug if a generic is available, penalty for failure to obtain precertification, dental and vision expenses and Non-PPO deductibles, copays and coinsurance except ER visit in case of emergency.	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 **In-Network PPO providers, see www.anthem.com or call 1-800-810-BLUE.**	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**.

Important Questions	Answers	Why this Matters:
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 . 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 PPO **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use Out-of-Area Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	15% coinsurance	15% coinsurance	50% coinsurance	LiveHealth online visit $20 copay (deductible waived).
	Specialist visit	15% coinsurance	15% coinsurance	50% coinsurance	
	Other practitioner office visit	15% coinsurance	15% coinsurance	50% coinsurance	Chiropractic services and acupuncture each limited to 12 visits/calendar year
	Preventive care/screening/ immunization	No charge	Not covered	Not covered	Only colonoscopies and sigmoidoscopies (subject to deductible/coinsurance) are covered with a Non-PPO or out-of-area provider.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	15% coinsurance	50% coinsurance	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use Out-of-Area Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	15% coinsurance	15% coinsurance	50% coinsurance	Repeat imaging may be subject to medical review.
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available from www.optumrx.com or call (800) 797-9791	Generic drugs	Retail $5 co-pay plus 20% cost of drug, $40 copay mail order	If you use a Non-PPO Pharmacy, you must pay the full cost of the prescription and file a claim with the PBM.	If you use a Non-PPO Pharmacy, you must pay the full cost of the prescription and file a claim with the PBM.	• Some prescriptions are subject to preapproval, quantity limits or step therapy. • No charge for FDA approved generic contraceptives (or brand name if generic is medically inappropriate) • Max copay of $100 per brand name drug (if unavailable as generic and unavailable through mail order). Also, $100 maximum co-payment for injectables. • You pay 100% for a brand drug if a generic is available. Excluded amounts do not count towards the out of pocket maximum.
	Preferred brand drugs	Retail 20% cost of drug, $60 copay mail order			
	Non-Preferred brand drugs	Retail $15 copay plus 20% of the cost of drug, $60 copay mail order			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	15% coinsurance plus any amount over $500	50% coinsurance plus any amount over $500	For hospital facility charge, max of $6,000 is payable for an arthroscopy, $2,000 for cataract surgery, $1,500 for colonoscopy.
	Physician/surgeon fees	15% coinsurance	15% coinsurance	50% coinsurance	
If you need immediate medical	Emergency room services	15% coinsurance	15% coinsurance	15% coinsurance	Must be for an Emergency Medical Condition as defined by the Plan.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use Out-of-Area Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
attention	Emergency medical transportation	15% coinsurance	15% coinsurance	15% coinsurance	You pay 100% for Non-emergency ambulance
	Urgent care	15% coinsurance	15% coinsurance	50% coinsurance	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	15% coinsurance	50% coinsurance	Preauthorization is required to avoid a $250 penalty
	Physician/surgeon fee	15% coinsurance	15% coinsurance	50% coinsurance	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	15% coinsurance	15% coinsurance	50% coinsurance	LiveHealth online visit $20 copay (deductible waived).
	Mental/Behavioral health inpatient services	15% coinsurance	15% coinsurance	50% coinsurance	Preauthorization is required to avoid a $250 penalty.
	Substance use disorder outpatient services	15% coinsurance	15% coinsurance	50% coinsurance	LiveHealth online visit $20 copay (deductible waived).
	Substance use disorder inpatient services	15% coinsurance	15% coinsurance	50% coinsurance	Preauthorization is required to avoid a $250 penalty.
If you are pregnant	Prenatal and postnatal care	No charge	Preventive prenatal screenings are not covered. All other services 15% coinsurance after the deductible	Preventive prenatal screenings are not covered. All other services 50% coinsurance after the deductible	Ultrasound payable as a diagnostic test
	Delivery and all inpatient services	15% coinsurance	15% coinsurance	50% coinsurance	Preauthorization is required to avoid a $250 penalty if extended stay is expected.
If you need help recovering or have other special health needs	Home health care	15% coinsurance	15% coinsurance	50% coinsurance	150 visits per calendar year.
	Rehabilitation services	15% coinsurance	15% coinsurance	50% coinsurance	Limited to 12 (or in some cases, 24 visits) per calendar year.
	Habilitation services	Not covered	Not covered	Not covered	You pay 100% of these services.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use Out-of-Area Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
	Skilled nursing care	15% coinsurance	15% coinsurance	50% coinsurance	120 days per disability
	Durable medical equipment	15% coinsurance	15% coinsurance	50% coinsurance	Rental is covered unless purchase is less expensive
	Hospice service	15% coinsurance	15% coinsurance	50% coinsurance	Covered for terminally ill patient
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Not covered	If your employer provides vision coverage, it will be under a separate vision plan.
	Glasses	Not covered	Not covered	Not covered	
	Dental check-up	Not covered	Not covered	Not covered.	If your employer provides dental coverage, it will be under a separate 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.)

- Brand name drugs if a generic is available
- Cosmetic surgery
- Dental care (may be offered under a separate dental plan)
- Habilitation services
- Long term care
- Non-emergency ambulance charges
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (may be covered under separate vision plan)
- Weight loss programs (except preventive services required by Health Reform)

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 (12 visits/calendar year for pain only)
- Bariatric Surgery (Gastric bypass covered if approved by Utilization Management)
- Chiropractic care (12 visits/calendar year)
- Hearing aids (Max $400 per aid payable once every 36 months for dependent children)
- Infertility treatment (only services to diagnose infertility are covered. Subsequent treatment not covered)
- Routine foot care

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 1-800-635-3105. 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 Fund Office at 1-800-635-3105. 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 1-800-635-3105.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-635-3105.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-635-3105.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-635-3105.

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** $6,000
- **Patient pays** $1,540

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	$10
Coinsurance	$1000
Limits or exclusions	$30
Total	**$1,540**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,560
- **Patient pays** $1,840

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	$200
Coinsurance	$770
Limits or exclusions	$370
Total	**$1,840**

Keep in mind that this Plan includes a **Health Reimbursement Arrangement (HRA)**. If you have available funds in your HRA, you may be reimbursed for certain eligible out-of-pocket costs as well as for certain types of medical expenses you incur that are not covered by the Plan

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.

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