The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage see www.acrtrust.org/plan-documents. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.HealthCare.gov/sbc-glossary/ or call **1-714-917-6100** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$350 per person, or $150 per person for Medicare-eligible retired participants** (until at least 3 people in the family have met the $350 per person deductible, or $150 per person deductible for Medicare-eligible retired participants) **each calendar year.**	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	**Yes**, Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	**Yes**, there is a **$100** deductible for brand name prescriptions. This deductible does not apply to Medicare-eligible retired participants.	You must pay all the costs up for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$3,000** per person and **$6,000** per family for network providers for medical. **$3,600** per person and **$7,200** per family for prescriptions. There is no out-of-pocket limit for out-of-network providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Charges by out-of-network providers (except those billed at in-network rates), premiums, balance-billed charges and health care this plan doesn't cover are not included in the out-of-pocket limit.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	**Yes.** See www.blueshieldca.com/findaprovider or call 1-714-917-6100 for a list of network providers	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Note that certain out-of-network services provided at or ordered by in-network health care

		facilities are covered at in-network rates. To help avoid paying higher rates or balance billing, check with your provider before you get services.
Do you need a referral to see a specialist?	**No.**	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	50% of allowed amount plus balance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
	Specialist visit	20% coinsurance	50% of allowed amount plus balance	None
	Preventive care/screening/ immunization	No charge	0% of allowed amount plus balance	None
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% of allowed amount plus balance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% of allowed amount plus balance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.acrtrust.org.	Generic drugs (Tier 1)	**Mail Order**: $16 copayment per prescription	Not Covered	Up to 90-day supply
		Retail (up to 34-day supply): 10% of cost with $8 min/$20 max per prescription **Retail (35 to 60-day supply)**: 10% of cost with $16 min/$40 max per prescription **Retail (61-day supply or more)**: 10% of cost with $24 min/$60 max per prescription	Not Covered	None
	Preferred brand drugs (Tier 2)	**Mail Order**: $40 copayment per prescription, after $100 deductible is met.	Not Covered	Up to 90-day supply
		Retail (up to 34-day supply): 20% of cost with $20 min/$50 max per prescription, after $100 deductible is met. **Retail (35 to 60-day supply)**: 20% of cost with $40 min/ $100 max per prescription, after $100 deductible is met. **Retail (61-day supply or more)**: 20% of cost with $60 min/$150 max per prescription, after $100 deductible is met.	Not Covered	None
	Non-preferred brand drugs (Tier 3)	**Mail Order**: $80 copayment per prescription, after $100 deductible is met.	Not Covered	Up to 90-day supply
		Retail (up to 34-day supply): 40% of cost with $40 minimum per prescription, after $100 deductible is met. **Retail (35 to 60-day supply)**: 40% of cost with $80 minimum per prescription, after $100 deductible is met. **Retail (90-day supply)**: 40% of cost with $120 minimum per prescription, after $100 deductible is met.	Not Covered	None
	Specialty drugs	See Retail price for Generic, Preferred brand, and Non-preferred brand drugs above	Not Covered	These prescriptions must be filled through Lumicera at 855-847-3533.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% of allowed amount plus balance	Max allowed amount of $4,000 for out-of-network provider

* For more information about limitations and exceptions, see the plan document at www.acrtrust.org.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% coinsurance	50% of allowed amount plus balance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	50% of allowed amount plus balance	Out-of-network provider service covered at 80% for "Qualified Emergency"; see Summary Plan Description at www.acrtrust.org for further information. Also, out-of-network air ambulance covered at in-network rates.
	Urgent care	20% coinsurance	50% of allowed amount plus balance	Out-of-network provider service covered at 80% for "Qualified Emergency"; see Summary Plan Description at www.acrtrust.org for further information.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% of allowed amount plus balance	None
	Physician/surgeon fees	20% coinsurance	50% of allowed amount plus balance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% of allowed amount plus balance	None
	Inpatient services	20% coinsurance	50% of allowed amount plus balance	None
If you are pregnant	Office visits	No charge	0% of allowed amount plus balance	Applies to preventive prenatal office visits
	Childbirth/delivery professional services	20% coinsurance	50% of allowed amount plus balance	None
	Childbirth/delivery facility services	20% coinsurance	50% of allowed amount plus balance	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% of allowed amount plus balance	None
	Rehabilitation services	20% coinsurance	50% of allowed amount plus balance	None
	Habilitation services	20% coinsurance	50% of allowed amount plus balance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	20% coinsurance	50% of allowed amount plus balance	Lifetime maximum of 365 days
	Durable medical equipment	20% coinsurance	50% of allowed amount plus balance	None
	Hospice services	20% coinsurance	50% of allowed amount plus balance	Lifetime maximum of 30 days
If your child needs dental or eye care	Children's eye exam	Covered through Vision Service Plan (VSP) - $20 copayment for Participants and dependents	Covered through VSP – any billed charge over $45	Under VSP, eye exams will not be covered more than once every 12 months. Also, if you choose contact lenses, there is an additional exam not covered by VSP. Contracted vision providers will give you a 15% discount on the cost of the additional exam.
	Children's glasses	Covered through Vision Service Plan (VSP) – no charge for lenses; any billed charge beyond $150 for frames	Covered through VSP – any billed charge over certain amount ranging from $45 - $85 depending on type of lenses; any billed charge over $47 for frames	Under VSP, lenses and frames will not be covered more than once every 12 months. Contact lenses are available in lieu of glasses once every 12 months for an amount up to $120 for an in-network provider and up to $105 for an out-of-network provider.
	Children's dental check-up	No charge if covered under United Concordia Dental Plan. If covered under Fee-For-Service Dental Plan, any billed charge beyond 100% of the Delta Dental PPO contracted rate or Delta Dental Premier contracted rate (not to exceed 100% of the dentist's usual, customary and reasonable fees).	No charge covered under United Concordia Dental Plan. If covered under Fee-For-Service Dental Plan, difference between billed charge and amount set forth on Delta Dental PPO contracted rate or Delta Dental Premier contracted rate, whichever is greater.	Under the Fee-For-Service Dental Plan, the maximum aggregate amount payable for Covered Dental Expense for Participants or dependents in any calendar year or portion thereof is $1,750 per person.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult) (Coverage available through United Concordia Dental Plan or Fee-For-Service Dental Plan)
- Eye exam, glasses, dental check-up for your child (Coverage available through VSP for eye exam and glasses, and through the United Concordia Dental Plan or Fee-For-Service Dental Plan for dental check-up)
- Infertility treatment
- Long-term care
- Private duty nursing
- Routine eye care (Adult) (Coverage available through VSP)
- Routine foot care unless medically necessary
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Chiropractic care
- Hearing aids
- Most coverage provided outside the United States. See www.acrtrust.org
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Beneifts Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For additional information on your rights to continue coverage, contact the plan at 1-714- 917-6100.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the Trust Office at 1-174-917-6100 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

* For more information about limitations and exceptions, see the plan document at www.acrtrust.org.

Language Access Services:

Spanish (Español): Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-714-917-6100.

Chinese (繁體中文): 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-714-917-6100。

Vietnamese (Tiếng Việt): Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-714-917-6100.

Korean (한국어): 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-714-917-6100 번으로 전화해 주십시오.

Tagalog (Tagalog): Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-714-917-6100.

Russian (**Русский):** Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-714-917-6100.

French Creole (Kreyòl Ayisyen): Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-714-917-6100.

Arabic (العربية) ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-714-917-6100.

French (Français): Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-714-917-6100.

Polish (Polski): Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-714-917-6100.

Japanese (日本語): 日本語を話される場合、無料の言語支援をご利用いただけます。1-714-917-6100 まで、お電話にてご連絡ください。

Italian (Italiano): In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-714-917-6100.

Portuguese (Português): Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-714-917-6100.

German (Deutsch): Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-714-917-6100.

Persian (Farsi) (فارسی): اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-714-917-6100 تماس بگیرید.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan document at www.acrtrust.org.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$350
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$350
Copayments	$0
Coinsurance	$2,250
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,600**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$350
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$350
Copayments	$64
Coinsurance	$1,410
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,824**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$350
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,500**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$350
Copayments	$0
Coinsurance	$190
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$540**

The plan would be responsible for the other costs of these EXAMPLE covered services.