RESOLUTION
CAL FIRE LOCAL 2881 53rd ANNUAL CONVENTION
SACRAMENTO, CA
JANUARY 10-13, 2019

SUBJECT: Peace Officer and Research Association of California (PORAC) Membership for CAL FIRE L2881 members

SUBMITTED BY: Executive Board

INTENT: Increase L2881 member participation in PORAC

FINANCIAL IMPACT: $2.00

Sunset Date: _____ Continues Indefinitely: YES

Estimated Annual Revenue: $114,000.00

WHEREAS, (1) PORAC was incorporated in 1953 as a professional federation of local, state and federal law enforcement agencies. PORAC currently represents over 70,000 public safety members and over 930 associations, making it the largest law enforcement organization in California and the largest statewide association in the nation; and

WHEREAS, (2) PORAC Membership affords advocacy at the local, state and federal level to make change in benefits and working conditions for public safety employees; and

WHEREAS, (3) PORAC members are afforded health benefits that protect their members in ways that could never be made available through CAL FIRE L2881 benefits; and

WHEREAS, (4) PORAC programs like, Insurance and Benefits Trust and Retiree Medical Trust are available benefit options to members of PORAC adding new ways for members to protect themselves and their families; and

WHEREAS, (5) PORAC as part of their Insurance and Benefits Trust, offers to members that participate in their medical plan, free body scanning/screening every 36 months or reduced cost body scanning for non-plan members as well as other benefits that are not currently available through CALPERS plans; and

WHEREAS, (6) In 2016, the CAL FIRE L2881 Executive Board voted to enroll all CAL FIRE L2881 peace officer members to ensure they have adequate protection and benefits from PORAC and the Legal Defense Fund; and

WHEREAS, (7) The CAL FIRE L2881 Executive Board sees a great benefit to involvement in PORAC for all members of CAL FIRE L2881; and therefore, be it

RESOLVED, (A) That CAL FIRE L2881 work with PORAC to enroll ALL dues members in PORAC" limited membership" for non-peace officer members with access to the medical benefit plans in PORAC, and further, be it

RESOLVED, (B) that CAL FIRE L2881 offer enrollment in PORAC for CAL FIRE Local 2881 retiree members, and further, be it

RESOLVED, (C) that CAL FIRE L2881 continue the membership of all L2881 Peace Officer Members as full/active members, and further, be it

RESOLVED, (D) that the "PASS THROUGH" costs of this membership be added as a line item in the 2019 CAL FIRE L2881 budget; and further, be it

RESOLVED, (E) that expenses associated with implementation of membership in PORAC be included in the PORAC Dues Costs.

ACTION:

To Executive Board of Directors_____ Adopt in Original Form_____

Adopt as Amended _____ Adopt as a Consolidation of Resolutions_____

Withdrawn by Author _____ Reject _____

Insurance & Benefits Trust
/ Committee of PORAC

Rates

2018 Anthem Blue Cross Rates

Basic	
Employee Only	$734.00
Employee and One Dependent	$1,540.00
Employee and Two or more Dependent(s)	$1,970.00

Supplement to Medicare	
Employee Only	$487.00
Employee and One Dependent	$970.00
Employee and Two or more Dependent(s)	$1,551.00

Maximum Out-of-Pocket Expense $3,000 per person/ $6,000 for a family.

Prescription Drugs

Retail	
Generic	$10.00 copay
Brand Formulary	$25.00 copay
Brand Non-Formulary	$45.00 copay

Mail Order	
Generic	$20.00 copay
Brand Formulary	$40.00 copay
Brand Non-Formulary	$75.00

Benefit Changes effective 2015: Body Scans will be subject to a maximum $1,000 coverage limit every 36 months.

⊕ 2017 Anthem Blue Cross Rates

⊕ 2016 Anthem Blue Cross Rates

⊕ 2015 Anthem Blue Cross Rates

⊕ 2014 Anthem Blue Cross Rates

⊕ 2013 Anthem Blue Cross Rates

⊕ 2012 Anthem Blue Cross Rates

⊕ 2011 Anthem Blue Cross Rates

⊕ 2010 Anthem Blue Cross Rates

Anthem Blue Cross Rates older than five years are available upon written request from the IBT Manager.

HEALTH

Anthem Blue Cross

anthem.com

800-288-6928

CalPERS

Calpers.ca.gov

888-225-7377

DISABILITY, LIFE & AD&D

Myers-Stevens & Toohey & Co. Inc.

PORACInsurance.org

800-827-4695

DENTAL & VISION

Delta Dental

DeltaDental.com

800-765-6003

VSP Vision Care

VSP.com

800-877-7195

HOME & AUTO

California Casualty

CalCas.com

888-513-5156

SUPPLEMENTAL

Aflac

Aflac.com/porac

949-255-1906

Insurance and Benefits Trust of PORAC
4010 Truxel Road, Sacramento, California
1-800-655-6397

Non-California Resident Plan

PORAC Prudent Buyer PPO Plan

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services — Coverage Period: 01/01/2019 – 12/31/2019

Anthem Blue Cross: PORAC Prudent Buyer PPO Non-California Resident Plan — Coverage for: Individual + Family | Plan Type: PPO

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, www.porac.org/insurance. 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 www.healthcare.gov/sbc-glossary/ call: 1-800-288-6928

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$300**/member or **$900**/family for In-Network Providers. **$600**/member or **$1,800**/family for Out-of-Network Providers.	Generally, you must pay all of 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. Prescription Drugs, Preventive care, Primary Care visit, and Specialist visit for In-Network Providers.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$3,000**/member or **$6,000**/family for In-Network Providers or Out-of-Network Providers combined. This plan has a separate Out of Pocket Maximum for Prescription Drugs **$3,000**/member or **$6,000**/family	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?	Premiums, Balance-Billing 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.
Will you pay less if you use a network provider?	Yes, Prudent Buyer PPO. See www.porac.org/insurance or call 1-800-288-6928 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). Be aware your network provider might use an out-of-network provider for some services (such as lab work). 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
		In-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/visit deductible does not apply	10% coinsurance	--------none--------
	Specialist visit	$20/visit deductible does not apply	10% coinsurance	--------none--------
	Preventive care/screening/ immunization	No charge	10% coinsurance	--------none--------
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	10% coinsurance	--------none--------
	Imaging (CT/PET scans, MRIs)	10% coinsurance	10% coinsurance	--------none--------
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.anthem.com/ca/pharmacyinformation/	Generic drugs	$10/prescription at retail; $20/prescription at mail order	100% up-front cost; paper claim may be submitted to request partial reimbursement	Covers up to a 30 day supply (retail prescription); 31-90 day supply (mail order prescription)
	Preferred brand drugs	$25/prescription at retail; $40/prescription at mail order	100% up-front cost; paper claim may be submitted to request partial reimbursement	Covers up to a 30 day supply (retail prescription); 31-90 day supply (mail order prescription)
	Non-preferred brand drugs	$45/prescription at retail; $75/prescription at mail order	100% up-front cost; paper claim may be submitted to request partial reimbursement	Covers up to a 30 day supply (retail prescription); 31-90 day supply (mail order prescription)
	Specialty drugs	$25/prescription preferred drug prescription retail; $45/prescription non-preferred drug prescription retail	100% up-front cost; paper claim may be submitted to request partial reimbursement	Pre-authorization required. 30 day maximum supply. No mail order available.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	10% coinsurance	--------none--------
	Physician/surgeon fees	10% coinsurance	10% coinsurance	--------none--------
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	--------none--------
	Emergency medical transportation	20% coinsurance	20% coinsurance	--------none--------
	Urgent care	10% coinsurance	10% coinsurance	--------none--------

* For more information about limitations and exceptions, see plan or policy document at www.porac.org/insurance.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	10% coinsurance	--------none--------
	Physician/surgeon fees	10% coinsurance	10% coinsurance	--------none--------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit 10% coinsurance Other Outpatient 10% coinsurance	Office Visit 10% coinsurance Other Outpatient 10% coinsurance	Office Visit --------none-------- Other Outpatient --------none--------
	Inpatient services	10% coinsurance	10% coinsurance	--------none--------
If you are pregnant	Office visits	10% coinsurance	10% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound)
	Childbirth/delivery professional services	10% coinsurance	10% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	10% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	10% coinsurance	100 visits/benefit period.
	Rehabilitation services	10% coinsurance	10% coinsurance	*See Therapy Services section in Evidence of Coverage.
	Habilitation services	10% coinsurance	10% coinsurance	
	Skilled nursing care	20% coinsurance	20% coinsurance	100 visits/benefit period.
	Durable medical equipment	20% coinsurance	20% coinsurance	--------none--------
	Hospice services	10% coinsurance	10% coinsurance	--------none--------
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	--------none--------
	Children's glasses	Not covered	Not covered	--------none--------
	Children's dental check-up	Not covered	Not covered	--------none--------

* For more information about limitations and exceptions, see plan or policy document at www.porac.org/insurance.

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.)		
• Cosmetic surgery	• Dental care (adult)	• Infertility treatment
• Long- term care	• Private-duty nursing	• Routine eye care (adult)
• Routine foot care unless you have been diagnosed with diabetes.	• Weight loss programs	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Bariatric surgery	• Chiropractic care 20 visits/benefit period.
• Hearing aids one hearing aid/ear every three years.	• Most coverage provided outside the United Stateswww.bcbs.com/bluecardworldwide	

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 Benefits Security Administration at (866) 444-EBSA (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.

Your Grievance and Appeals Rights: 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: Anthem Blue Cross Life and Health Insurance Company.
All requests for appeals should be submitted in writing by the Member or the Member's authorized representative, except where the acceptance of oral appeals is otherwise required by the nature of the appeal (e.g. urgent care). You or your authorized representative must submit a request for review to:

Anthem Blue Cross Life and Health Insurance Company
ATTN: Appeals
P.O. Box 4310, Woodland Hills, CA 91365-4310
1-800-288-6928

If you choose to contact the Plan, please contact: IBT of PORAC, 4010 Truxel Road, Sacramento, CA 95834.

* For more information about limitations and exceptions, see plan or policy document at www.porac.org/insurance.

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.

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 plan or policy document at https://eoc.anthem.com/eocdps/ca/aso.

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	$300
Specialist copayment	$20
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$12,840

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$140
Coinsurance	$2,480
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,980**

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

The plan's overall deductible	$300
Specialist copayment	$20
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$7,460

In this example, Joe would pay:

Cost Sharing	
Deductibles	$107
Copayments	$2,850
Coinsurance	$27
What isn't covered	
Limits or exclusions	$21
The total Joe would pay is	**$3,005**

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

The plan's overall deductible	$300
Specialist copayment	$20
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$2,010

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$60
Coinsurance	$326
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$686**

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

Language Access Services:

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

California Resident Plan

PORAC Prudent Buyer PPO Plan

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage Period: 01/01/2019– 12/31/2019**
Anthem Blue Cross: PORAC Prudent Buyer PPO Plan **Coverage for: Individual + Family | Plan Type: PPO**

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, www.porac.org/insurance. 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 www.healthcare.gov/sbc-glossary/ call: **1-800-288-6928**

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$300**/member or **$900**/family for In-Network Providers. **$600**/member or **$1,800**/family for Out-of-Network Providers.	Generally, you must pay all of 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. Prescription Drugs, Preventive care, Primary Care visit, and Specialist visit for In-Network Providers.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$3,000**/member or **$6,000**/family for In-Network Providers or Out-of-Network Providers combined. This plan has a separate Out of Pocket Maximum for Prescription Drugs **$3,000**/member or **$6,000**/family	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?	Premiums, Balance-Billing 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.
Will you pay less if you use a network provider?	Yes, Prudent Buyer PPO. See www.porac.org/insurance or call **1-800-288-6928** 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). Be aware your network provider might use an out-of-network provider for some services (such as lab work). 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
		In-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/visit deductible does not apply	10% coinsurance	--------none--------
	Specialist visit	$20/visit deductible does not apply	10% coinsurance	--------none--------
	Preventive care/screening/ immunization	No charge	10% coinsurance	--------none--------
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	10% coinsurance	--------none--------
	Imaging (CT/PET scans, MRIs)	10% coinsurance	10% coinsurance	--------none--------
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.anthem.com/ca/pharmacyinformation/	Generic drugs	$10/prescription at retail; $20/prescription at mail order	100% up-front cost; paper claim may be submitted to request partial reimbursement	Covers up to a 30 day supply (retail prescription); 31-90 day supply (mail order prescription)
	Preferred brand drugs	$25/prescription at retail; $40/prescription at mail order	100% up-front cost; paper claim may be submitted to request partial reimbursement	Covers up to a 30 day supply (retail prescription); 31-90 day supply (mail order prescription)
	Non-preferred brand drugs	$45/prescription at retail; $75/prescription at mail order	100% up-front cost; paper claim may be submitted to request partial reimbursement	Covers up to a 30 day supply (retail prescription); 31-90 day supply (mail order prescription)
	Specialty drugs	$25/prescription preferred drug prescription retail; $45/prescription non-preferred drug prescription retail	100% up-front cost; paper claim may be submitted to request partial reimbursement	Pre-authorization required. 30 day maximum supply. No mail order available.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	10% coinsurance	--------none--------
	Physician/surgeon fees	10% coinsurance	10% coinsurance	--------none--------
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	--------none--------
	Emergency medical transportation	20% coinsurance	20% coinsurance	--------none--------

* For more information about limitations and exceptions, see plan or policy document at https://coc.anthem.com/eocdps/ca/aso.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Urgent care	10% coinsurance	10% coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	10% coinsurance	--------none--------
	Physician/surgeon fees	10% coinsurance	10% coinsurance	--------none--------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit 10% coinsurance Other Outpatient 10% coinsurance	Office Visit 10% coinsurance Other Outpatient 10% coinsurance	Office Visit --------none-------- Other Outpatient --------none--------
	Inpatient services	10% coinsurance	10% coinsurance	--------none--------
If you are pregnant	Office visits	10% coinsurance	10% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	10% coinsurance	10% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	10% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	10% coinsurance	100 visits/benefit period.
	Rehabilitation services	10% coinsurance	10% coinsurance	*See Therapy Services section in Evidence of Coverage.
	Habilitation services	10% coinsurance	10% coinsurance	
	Skilled nursing care	20% coinsurance	20% coinsurance	100 visits/benefit period.
	Durable medical equipment	20% coinsurance	20% coinsurance	--------none--------
	Hospice services	10% coinsurance	10% coinsurance	--------none--------
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	--------none--------
	Children's glasses	Not covered	Not covered	--------none--------
	Children's dental check-up	Not covered	Not covered	--------none--------

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.)

- Cosmetic surgery
- Long- term care
- Routine foot care unless you have been diagnosed with diabetes.
- Dental care (adult)
- Private-duty nursing
- Weight loss programs
- Infertility treatment
- Routine eye care (adult)

* For more information about limitations and exceptions, see plan or policy document at www.porac.org/insurance.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Hearing aids one hearing aid/ear every three years.	• Bariatric surgery • Most coverage provided outside the United Stateswww.bcbs.com/bluecardworldwide	• Chiropractic care 20 visits/benefit period.

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 Benefits Security Administration at (866) 444-EBSA (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.

Your Grievance and Appeals Rights: 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: Anthem Blue Cross Life and Health Insurance Company.
All requests for appeals should be submitted in writing by the Member or the Member's authorized representative, except where the acceptance of oral appeals is otherwise required by the nature of the appeal (e.g. urgent care). You or your authorized representative must submit a request for review to:

Anthem Blue Cross Life and Health Insurance Company
ATTN: Appeals
P.O. Box 4310, Woodland Hills, CA 91365-4310
1-800-288-6928

If you choose to contact the Plan, please contact: IBT of PORAC, 4010 Truxel Road, Sacramento, CA 95834.

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.

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 plan or policy document at www.porac.org/insurance.

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	$300
Specialist copayment	$20
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$40
Coinsurance	$1,240
What isn't covered	
Limits or exclusions	$96
The total Peg would pay is	**$1,676**

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

The plan's overall deductible	$300
Specialist copayment	$20
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$120
Copayments	$200
Coinsurance	$13
What isn't covered	
Limits or exclusions	$6,041
The total Joe would pay is	**$6,374**

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

The plan's overall deductible	$300
Specialist copayment	$20
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$60
Coinsurance	$222
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$582**

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

Language Access Services:

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW, Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.