Med. Exp. Reimb. Plan (So. Cal. Public Safety Retiree Med. Trust) (sponsored by Alhambra Police Officers' Assn.)

Coverage Period: Begins on or after 2/1/15

Coverage for: Eligible Retiree, Spouse/DP, Child

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

Plan Type: Retiree Medical Expense Reimbursement

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the Plan document by calling 1-800-700-6762.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	There is no deductible on this Plan. This Plan reimburses you up to your monthly benefit level from the Plan for the cost of medical expenses (including deductibles) you have paid (and for which you didn't receive reimbursement from any other source) to the extent those medical expenses are tax deductible under Internal Revenue Code ("IRC") Section 213. IRC Section 213 generally allows you to deduct expenses you incur for the diagnosis, cure, mitigation, or prevention of disease or injury.
Are there other deductibles for specific services?	**No**	You don't need to meet any deductibles in this Plan.
Is there an out–of–pocket limit on my expenses?	**No**	There is no out-of-pocket limit on this Plan. You will remain responsible to pay all medical expenses and premiums that exceed your monthly benefit level from this Plan.
What is not included in the out–of–pocket limit?	This Plan has no out-of-pocket limit.	Not applicable because there is no out-of-pocket limit on your expenses.
Is there an overall annual limit on what the Plan pays?	**Yes**; amount varies by each Beneficiary's benefit level	Your annual reimbursement benefits are limited to 12 times your monthly benefit level (not to exceed $500/month for an Eligible Retiree who has 12 or more years of Active Service in the Plan). This is a retiree-only plan, i.e., you may claim your reimbursement benefits only after you retire.
Does this plan use a network of providers?	**No**	This is a medical expense reimbursement plan. There is no network.
Do I need a referral to see a specialist?	**No**	This Plan does not require you to obtain a referral to see the specialist you choose.
Are there services this Plan doesn't cover?	**Yes**	This Plan does not cover any medical expenses already paid by your primary health insurance policy (or other source), or any medical expenses that are not tax deductible under IRC Section 213 (which generally allows you to deduct expenses you incur for the diagnosis, cure, mitigation, or prevention of disease or injury). IRS Publication 502 provides an extensive list of deductible and non-deductible medical expenses.

- **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 your regular medical insurance 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 your primary insurance policy 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 reimburse you for your **deductibles**, **copayments**, **coinsurance** and **balance billing** amounts, regardless of whether your provider was in-network or out-of-network. **This is not your primary insurance policy.** This Plan will reimburse you for out-of-pocket medical expenses, up to the amount of your monthly benefit level under this Plan. You bear any remaining costs after your primary insurance coverage and your monthly benefit level under this Plan have been exhausted.

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	Assuming the charge is lower under your primary insurance policy for "in-network" than for "out-of-network" providers, your cost will be lower (maybe zero) if you use an in-network provider. This Plan will reimburse you for certain out-of-pocket costs not paid by your primary health insurance policy, if there are any such costs after using an in-network provider.	Assuming the charge is lower under your primary insurance policy for "in-network" than for "out-of-network" providers, your cost will be higher if you use an out-of-network provider. This Plan will reimburse you for certain out-of-pocket costs not paid by your primary health insurance policy, and those costs will likely be higher if you use out-of-network providers.	Your reimbursement is limited to the amount of your benefit level under this Plan. Also, this Plan only reimburses you for medical expenses that are tax deductible under Internal Revenue Code Section 213 (generally, expenses you incur for the diagnosis, cure, mitigation, or prevention of disease or injury).
	Specialist visit			
	Other practitioner office visit			
	Preventive care/screening/immunization			

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 have a test	Diagnostic test (x-ray, blood work)	Same as above under "If you visit a health care provider's office or clinic"	Same as above under "If you visit a health care provider's office or clinic"	Same as above under "If you visit a health care provider's office or clinic"
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition	Generic drugs	Assuming the charge is lower under your primary insurance policy for "in-network" than for "out-of-network" providers, your cost will be lower (maybe zero) if you use an in-network provider. This Plan will reimburse you for certain out-of-pocket costs not paid by your primary health insurance policy, if there are any such costs after using an in-network provider.	Assuming the charge is lower under your primary insurance policy for "in-network" than for "out-of-network" providers, your cost will be higher if you use an out-of-network provider. This Plan will reimburse you for certain out-of-pocket costs not paid by your primary health insurance policy, and those costs will likely be higher if you use out-of-network providers.	The drug must be prescribed or be insulin, and the amount reimbursed is limited to your monthly benefit level.
	Preferred brand drugs			
	Non-preferred brand drugs			
	Specialty drugs			

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Assuming the charge is lower under your primary insurance policy for "in-network" than for "out-of-network" providers, your cost will be lower (maybe zero) if you use an in-network provider. This Plan will reimburse you for certain out-of-pocket costs not paid by your primary health insurance policy, if there are any such costs after using an in-network provider.	Assuming the charge is lower under your primary insurance policy for "in-network" than for "out-of-network" providers, your cost will be higher if you use an out-of-network provider. This Plan will reimburse you for certain out-of-pocket costs not paid by your primary health insurance policy, and those costs will likely be higher if you use out-of-network providers.	Your reimbursement is limited to the amount of your benefit level under this Plan. Also, this Plan only reimburses you for medical expenses that are tax deductible under Internal Revenue Code Section 213 (generally, expenses you incur for the diagnosis, cure, mitigation, or prevention of disease or injury).
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room services			
	Emergency medical transportation			
	Urgent care			
If you have a hospital stay	Facility fee (e.g., hospital room)			
	Physician/surgeon fee			
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services			
	Mental/Behavioral health inpatient services			
	Substance use disorder outpatient services			
	Substance use disorder inpatient services			
If you are pregnant	Prenatal and postnatal care			
	Delivery and all inpatient services			
If you need help recovering or have other special health needs	Home health care			
	Rehabilitation services			
	Habilitation services			
	Skilled nursing care			
	Durable medical equipment			
	Hospice service			
If your child needs dental or eye care	Eye exam			
	Glasses			
	Dental check-up			

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover: This Plan will reimburse you only for tax-deductible medical expenses (i.e., expenses you incur for the diagnosis, cure, mitigation, or prevention of disease or injury); and health, dental, and vision insurance premiums. The following is a list of some expenses that would not be covered by this Plan. **(This isn't a complete list. Check your Plan document and IRS Publication 502, available at http://www.irs.gov/pub/irs-pdf/p502.pdf, for other excluded services.)**

• Bariatric surgery, unless for a specific disease diagnosed by a doctor	• Health club dues	• Premiums for insurance covering benefits other than health, dental, vision or prescription drug benefits
• Cosmetic surgery, hair removal, hair transplant, or teeth whitening services	• Medicines and drugs brought in (or ordered shipped) from another country	• Private-duty nursing care, unless providing medical, not personal or household services
• Fertility treatment expenses, unless they are tax-deductible medical expenses	• Non-prescription drugs and medicines, except insulin	• Weight loss programs, unless the treatment is for a specific disease diagnosed by a doctor

Other Covered Services This Plan will reimburse you for tax-deductible medical expenses; and health, dental, and vision insurance premiums, up to the amount of your monthly benefit level. The following is a list of some expenses that would be covered by this Plan. **(This isn't a complete list. Check your Plan document and IRS Publication 502, available at http://www.irs.gov/pub/irs-pdf/p502.pdf, for other covered services.)**

• Acupuncture	• Hearing aids	• Routine eye care
• Chiropractic services for medical care	• Non-emergency medical care outside the U.S., if the services would be tax-deductible if performed within the U.S.	• Routine foot care
• Dental care (if not cosmetic)		

Your Rights to Continue Coverage:

If your contributions to this Plan cease, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to continue contributions to the Plan. **Please note: The application of COBRA to this Plan differs from a typical health plan because benefits under this Plan begin *after* retirement.** (Under a typical health plan, coverage would begin immediately following active employment.) Any such rights to continue contributions may provide benefits from this Plan after retirement. The right to continue COBRA contributions will be limited in duration. Self-pay contributions may be significantly higher than the contributions paid during your employment. Other limitations on your rights to continue contributions may also apply. You may wish to continue COBRA contributions, as that could help you achieve eligibility for benefits under the Plan, or to attain a higher benefit level. See the COBRA General Notice, which you can obtain from the Trust Office if you do not have a copy.

For more information on your rights to continue contributions, contact the Plan administrator at 1-800-700-6762. You may also contact 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 Appeal Rights:

If you have a complaint or are dissatisfied with a denial of claim under your Plan, you have the right to **appeal the denial**. For questions about your rights, questions about this notice, or other Plan assistance, you can contact: Delta Health Systems at 1-800-700-6762 or P.O. Box 2487, Stockton, California 95201. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Language Access Services:

Para obtener asistencia en español, llame al 1-800-700-6762.

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
- **Primary health policy pays:** $6,750
- **This Plan reimburses Patient:** $790*
- **Patient pays out-of-pocket:** $0*

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	150
Coinsurance	0
Limits or exclusions	140
Total Before Reimbursement	**790**
Reimbursement from this Plan	790*
Total After Reimbursement	**0***

*Assumes patient's benefit level from this Plan is $375/month (for 9 yrs Active Service), costs are reimbursed over 3 or more months, and benefits from this Plan were not already used for other expenses, such as premiums.

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

- **Amount owed to providers:** $5,400
- **Primary health policy pays:** $4,200
- **This Plan reimburses Patient:** $1,200*
- **Patient pays out-of-pocket:** $0*

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	150
Coinsurance	0
Limits or exclusions	550
Total Before Reimbursement	**1,200**
Reimbursement from this Plan	1,200*
Total After Reimbursement	**0***

*Assumes patient's benefit level from this Plan is $375/month (for 9 yrs of Active Service), costs are reimbursed over 4 or more months, and benefits from this Plan were not already used for other expenses, such as premiums.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**. **However, this Plan also reimburses medical 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. However, this Plan reimburses costs for out-of-network providers at the same amount as in-network providers, i.e., up to your benefit level.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see that there may be **deductibles**, **copayments**, and **coinsurance** for you to pay out-of-pocket, even if you have a primary insurance policy.

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. 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?

✓ Coverage Examples may be useful to show how this Plan supplements your primary health insurance policy, but they are not useful for comparing this Plan to other expense reimbursement plans.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost when comparing primary insurance plans is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay out-of-pocket, for costs such as **copayments**, **deductibles**, and **coinsurance**. **This Plan is a reimbursement plan that helps you pay out-of-pocket expenses remaining after your primary insurance has paid its benefits.** (Bear in mind that you may also have access to a health savings account (HSA), flexible spending arrangement (FSA) or health reimbursement account (HRA) to help you pay out-of-pocket expenses.)