**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.pipetradesbenefits.org or by calling 1-877-811-4474.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | $100.00 Annually for In-Network Services | Maximum of two deductibles per family, per year. In-Network deductible does not count towards Out-of-Network deductible. |
| **Are there other deductibles for specific services?** | $200.00 Annually for Out-of-Network Services | Out-of-Network deductible counts toward the In-Network deductible. |
| **Is there an out–of–pocket limit on my expenses?** | Yes. $5,000 for In-Network services only. | 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?** | Charges incurred Out-of-Network will not be included in the out-of-pocket limit. | There's no limit on how much you could pay during a coverage period for your share of the cost of out-of-network covered services. |
| **Is there an overall annual limit on what the plan pays?** | No | There is no annual maximum on Essential Benefits. |
| **Does this plan use a network of providers?** | Yes. For a list of preferred providers, see www.blueshieldca.com or call 1-877-811-4474 | 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**. |
| **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 6. 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 Blue Shield of California **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** 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 | 10% of Contract | 30% of UCR | No limitations, no exceptions |
| | Specialist visit | 10% of Contract | 30% of UCR | No limitations, no exceptions |
| | Other practitioner office visit | 10% of Contract | 30% of UCR | No limitations, no exceptions |
| | Preventive care/screening/immunization | 10% of Contract | 30% of UCR | Well Baby Care from birth to 2nd birthday. Routine Exam: One exam per year 2-19 and over 65. One exam every two years ages 20-64. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 10% of Contract | 30% of UCR | No limitations, no exceptions |
| | Imaging (CT/PET scans, MRIs) | 10% of Contract | 30% of UCR | No limitations, no exceptions |
| **If you need drugs to treat your illness or condition** | Generic drugs | 20% of Cost | Not applicable | No limitations, no exceptions |
| | Preferred brand drugs | 30% of Cost | Not applicable | No limitations, no exceptions |
| | Non-preferred brand drugs | 50% of Cost | Not applicable | No limitations, no exceptions |

| 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 |
|---|---|---|---|---|
| More information about **prescription drug coverage** is available at www.pipetradesbenefits.org. | Specialty drugs | 10% of contract rate, after deductible | Not covered | Specialty Drugs costing more than $500 must be obtained through the PBM Specialty Pharmacy. Not covered unless Pre-Certified. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% of Contract | 30% of UCR | No limitations, no exceptions. |
| | Physician/surgeon fees | 10% of Contract | 30% of UCR | No limitations, no exceptions. |
| **If you need immediate medical attention** | Emergency room services | 10% of Contract | 30% of UCR | No limitations, no exceptions. |
| | Emergency medical transportation | 10% of Contract | 30% of UCR | No limitations, no exceptions. |
| | Urgent care | 10% of Contract | 30% of UCR | No limitations, no exceptions. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% of Contract | 30% of UCR | All inpatient non-emergency hospital stays must be pre-certified. |
| | Physician/surgeon fee | 10% of Contract | 30% of UCR | All inpatient non-emergency hospital stays must be pre-certified. |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | 10% of Contract | 30% of UCR | No limitations, no exceptions. |
| | Mental/Behavioral health inpatient services | 10% of Contract | 30% of UCR | Not covered unless pre-certified. |
| | Substance use disorder outpatient services | 10% of Contract | 30% of UCR | No limitations, no exceptions. Plans EAP: (800) 378-1109 |
| | Substance use disorder inpatient services | 10% of Contract | 30% of UCR | No limitations, no exceptions. Plans EAP: (800) 378-1109 |
| **If you are pregnant** | Prenatal and postnatal care | 10% of Contract | 30% of UCR | No limitations, no exceptions. |
| | Delivery and all inpatient services | 10% of Contract | 30% of UCR | No limitations, no exceptions. |

| 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 help recovering or have other special health needs** | Home health care | 10% of Contract | 30% of UCR | No coverage for Non-preferred home health care unless Pre-Certified. 100 Visit Maximum Per Year, must be within 14 days of hospital discharge. |
| | Rehabilitation services | 10% of Contract | 30% of UCR | No limitation, no exceptions for physical therapy and acupuncture combined. |
| | Habilitation services | 10% of Contract | 30% of UCR | No limitation, no exceptions for physical therapy and acupuncture combined. |
| | Skilled nursing care | 10% of Contract | 30% of UCR | No coverage for Non-preferred home health care unless Pre-Certified. 100 Visit Maximum Per Year, must be within 14 days of hospital discharge. |
| | Durable medical equipment | 10% of Contract | 30% of UCR | Durable Medical Equipment, not covered unless Pre-Certified by the Plan. |
| | Hospice service | 10% of Contract | 30% of UCR | Not covered unless Pre-Certified by the Plan. |
| **If your child needs dental or eye care** | Eye exam | No Charge | $40 allowance | Once every 12 months. |
| | Glasses | No Charge for standard frames and lenses | Allowance varies based on lens type and $40 allowance for frames | Once every 24 months |
| | Dental check-up | $50 deductible, 3 per family. 10% of contract amount. | $50 deductible, 3 per family. 30% of UCR | $0 calendar year dental maximum for children under the age of 18. $3,000 calendar year maximum. $5,000 lifetime maximum for Orthodontics. |

## 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.)** | | |
|---|---|---|
| • Bariatric Surgery – unless Pre-Certified by the Plan. | • Cosmetic Surgery | • Infertility Treatment |
| • Weight Loss Programs | • Dependent pregnancy | |

| **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 | • Hearing Aids | • Private-duty nursing |
| • Audiology and Hearing Aids | • Long Term Care | • Routine eye care (Adult) |
| • Chiropractic care | • Non-emergency care when traveling outside the U.S. | • Routine foot care |

## Timely Filing Limits

Claims will not be paid if they are submitted more than 12 months after the expense was incurred, except in the absence of legal capacity.

## 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 must also apply.
For more information on your rights to continue coverage, contact the Plan at (916) 457-0821. 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 x616565 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: U. A. Local 447 Pipe Trades Trust Fund at (916) 457-0821 or 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 (877) 811-4475.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (877) 811-4474.]

[Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** (877) 811-4474.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (877) 811-4474.]

*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** $6940
- **Patient pays** $ 600

**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 |
| Copays | $0 |
| Coinsurance | $500 |
| Limits or exclusions | $0 |
| **Total** | **$600** |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4800
- **Patient pays** $ 600

**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 |
| Copays | $0 |
| Coinsurance | $500 |
| Limits or exclusions | $0 |
| **Total** | **$600** |

# 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.