



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 <u>deductible</u> ?	\$200.00 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 <u>deductibles</u> for specific services?	\$200.00 Annually for Out-of-Network Services	Out-of-Network deductible counts toward the In-Network deductible.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$10,000 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 <u>out-of-pocket limit</u> ?	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 <u>network of providers</u> ?	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 <u>specialist</u> ?	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 .

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- **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 <u>provider's</u> 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 2 nd 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

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U. A. Local 447 Health and Welfare: Blue Shield of California Coverage Period: 1/1/2016-12/31/16

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

Coverage for: Retiree Participants Plan Type: PPO

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 <u>prescription drug coverage</u> 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.

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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	10% of Contract	30% of UCR	Not covered unless for a Medical Condition
	Glasses	No Coverage	No Coverage	
	Dental check-up	No Coverage	No Coverage	

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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 <u>excluded services</u> .)		
• 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.

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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, kwijigo holne' (877) 811-4474.]

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

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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 \$ 934

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	\$200
Copays	\$0
Coinsurance	\$734
Limits or exclusions	\$0
Total	\$934

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

- Amount owed to providers: \$5,400
- Plan pays \$4680
- Patient pays \$ 720

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	\$200
Copays	\$0
Coinsurance	\$520
Limits or exclusions	\$0
Total	\$720

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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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