U.A. Local 467 Self-funded PPO Health and Welfare Plan:

Coverage Period: 01/01/2015 - 12/31/2015

Joint Board of Trustees, U.A. Local 467 Health & Welfare Trust

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual + Family | **Plan Type:** PPO

This is only a summary of the self-funded portion of your Plan. There is a separate Summary for Kaiser benefits. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **http://local467benefits.com/ppo** or by calling (408)-288-4400**.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$50 person/$150 family per year.** Does not apply to preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	**Yes**. Covered dental benefits – Individual **$50** per lifetime, Family **$200** per lifetime.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	**Yes.** For PPO, **$2,050** person. For Non-PPO, **No limit**.	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?	Deductibles/Copayments to non-PPOs, Prescription Co-payments, Drug addiction, & Alcohol or Chemical dependency, Premiums, Balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they do not count toward the **out–of–pocket limit**.
Is there an overall annual limit on what the plan pays?	**No.**	The chart starting on page 2 describes any limits on what the plan will pay for *specific* coverage services, such as office visits.
Does this plan use a network of providers?	**Yes**. For a complete list of Blue Cross' Participating Providers please call the Trust Fund Office or call Blue Cross at 1-800-688-3828.	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 don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan	**Yes**.	Some of the services this plan does not cover are listed on page 6. See

Questions: Call **1-408-288-4400.**

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.dol.gov/ebsa/healthreform** or call 1-408-288-4400 to request a copy.

does not cover?		your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** 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 **preferred providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not Applicable	Not Applicable	————none————
	Specialist visit	10% of PPO rate	40% of UCR plus any charges above UCR	————none————
	Other practitioner office visit	10% of PPO rate for chiropractor and acupuncture	40% of UCR plus any charges above UCR	Chiropractic/Acupuncture: Limited to 22 visits per calendar year. Limited to $120 for x-rays taken in association with these forms of treatment /injury.
	Preventive care/ screening/immunization	10% of PPO rate (for immunizations).	40% of UCR plus any charges above UCR (for immunizations).	Limited to one physical examination every 12 months.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge.	40% of UCR plus any charges above UCR.	————none————
	Imaging (CT/PET scans, MRIs)	10% of PPO rate.	40% of UCR plus any charges above UCR.	————none————

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
If you need drugs to treat your illness or condition: More information about prescription drug coverage is available at www.scriptcare.com or 1-866-807-0072. For Specialty Drugs please use the SCL Specialty Pharmacy Program and contact 1-866-443-1991 for assistance.	Generic drugs	10% or $5 copay (Retail and Mail order).	Non-participating pharmacies are not covered.	Covers up to a 30 day supply (retail prescription); up to 90 day supply (mail order prescription).
	Preferred brand drugs	10% or $5 copay (Retail and Mail Order).	Non-participating pharmacies are not covered.	Covers up to a 30 day supply (retail prescription); up to 90 day supply (mail order prescription).
	Non-preferred brand drugs	10% or $5 copay (Retail and Mail Order).	Non-participating pharmacies are not covered.	Covers up to a 30 day supply (retail prescription); up to 90 day supply (mail order prescription).
	Specialty drugs	10% or $5 copay (Retail and Mail Order).	Non-participating pharmacies are not covered.	Covers up to a 30 day supply (retail prescription); up to 90 day supply (mail order prescription).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% of PPO rate.	40% of UCR plus any charges above UCR.	——————none——————
	Physician/Surgeon fees	10% of PPO rate.	40% of UCR plus any charges above UCR.	——————none——————
If you need immediate medical attention	Emergency room services	10% of covered charges.	40% of UCR plus any charges above UCR.	——————none——————
	Urgent Care	10% of covered charges.	40% of UCR plus any charges above UCR.	——————none——————
	Emergency medical transportation	10% of covered charges.	40% of UCR plus any charges above UCR.	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	10% of covered charges.	40% of UCR plus any charges above UCR.	——————none——————
	Physician/Surgeon fee	10% of covered charges.	40% of UCR plus any charges above UCR.	——————none——————

Common Medical Event	Services You May Need	Your cost if you use an Preferred Provider	Your cost if you use an Non-Preferred Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% of PPO rate.	40% of UCR plus any charges above UCR.	——————none——————
	Mental/Behavioral health inpatient services	10% of PPO rate.	40% of UCR plus any charges above UCR.	——————none——————
	Substance use disorder outpatient services	10% of covered charges.	40% of UCR plus any charges above UCR.	——————none——————
	Substance use disorder inpatient services	No charge (1st stay), 20% (2nd stay).	40% of UCR plus any charges above UCR.	——————none——————
If you are pregnant	Prenatal and postnatal care	10% of covered charges.	40% of UCR plus any charges above UCR.	——————none——————
	Delivery and all inpatient services	10% of covered charges.	40% of UCR plus any charges above UCR.	——————none——————
If you need help recovering or have other special health needs	Home health care	10% of covered charges.	40% of UCR plus any charges above UCR.	Charges for care following a hospital or convalescent nursing home stay during the first 100 days, or 100 visits in any 12 consecutive months.
	Rehabilitation services (Physical, Speech Therapy)	10% of covered charges.	40% of UCR plus any charges above UCR.	——————none——————
	Habilitation services	Not covered.	Not covered.	——————none——————
	Skilled nursing care	10% of PPO rate.	40% of UCR plus any charges above UCR	For care commencing within 14 days of a hospital stay of at least 3 days.
	Durable medical equipment	10% of covered charges.	40% of UCR plus any charges above UCR.	——————none——————
	Hospice service	Not covered.	Not covered.	——————none——————
If your child needs dental or eye care	Eye exam	Covered up to VSP allowances.	Up to $45.	$15 copayment every plan year; Limited to one exam every 12 months. See your VSP Booklet.

Common Medical Event	Services You May Need	Your cost if you use an Preferred Provider	Your cost if you use an Non-Preferred Provider	Limitations & Exceptions
	Glasses	Covered up to VSP allowances.	$45-$105(lenses)/ $47(frames).	Limited to one set of lenses every 12 months; Limited to One pair of frames every 24 months. See your VSP Booklet.
	Dental check-up	Covered separately through Delta Dental. No charge.	Not covered.	$50 deductible per patient per lifetime. See your Delta Dental Booklet.

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
- Cosmetic surgery (procedures not specifically covered under the Plan)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Weight loss programs

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
- Routine eye care (Adult)
- Chiropractic care
- Routine foot care
- Dental care (Adult)
- Non-emergency care when traveling outside the U.S. (if made during the first sixty (60) days of an absence)

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 may also apply.

For more information on your rights to continue coverage, contact the plan at 1-408-288-4400. 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 x61565 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 the Trust Fund Office at (408) 288-4400 or P.O. Box 5057, San Jose CA 95150, or contact 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 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.**

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:** $26,680
- **Plan pays** $24,630
- **Patient pays** $2,050

Sample care costs:

Hospital charges (mother)	$15,000
Routine obstetric care	$4,300
Hospital charges (baby)	With Mother charges
Anesthesia	$4,800
Laboratory tests	$1,000
Prescriptions	$400
Radiology	$1,100
Vaccines, other preventive	$80
Total	**$26,680**

Patient pays:

Deductibles	$50
Co-pays	$ 0
Co-insurance	$2,000
Limits or exclusions	$0
Total	**$2,050**

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

- **Amount owed to providers:** $4,100
- **Plan pays** $3,379
- **Patient pays** $721

Sample care costs:

Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$4,100**

Patient pays:

Deductibles	$50
Co-pays	$150
Co-insurance	$231
Limits or exclusions	$290
Total	**$721**

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**, **co-payments**, and **co-insurance** 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 (which applies to those on COBRA or making self-payments). Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.