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.scptac.org or by calling 1-800-595-7473. The Uniform Glossary can be accessed at: www.dol.gov/ebsa/healthreform.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$250** individual / **$750** family	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 documents 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. **$50** for prescription drugs and **$50** per device for hearing aid. There are no other specific **deductibles.**	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use.
Is there an out–of–pocket limit on my expenses?	**No.**	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out–of–pocket limit?	This plan has no **out-of-pocket limit**.	Not applicable because there's no **out-of-pocket limit** on your expenses.
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 covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of preferred providers, see www.blueshieldca.com or call 1-800-595-7473.	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. Note that 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 5. 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 in-network **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	No charge	Disallowed amount	---none---
	Specialist visit	No charge	Disallowed amount	---none---
	Other practitioner office visit	No charge	Disallowed amount	Acupuncture services must be performed by a medical doctor.
	Preventive care/screening/immunization	No charge	Disallowed amount	---none---
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Disallowed amount	---none---
	Imaging (CT/PET scans, MRIs)	No charge	Disallowed amount	---none---

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.scptac.org.	Generic drugs	$50 deductible	$50 deductible	• 100% for the first $1,800 • 50% $1,801 - $6,000 • 65% above $6,000
	Preferred brand drugs	$50 deductible	$50 deductible	• 100% for the first $1,800 • 50% $1,801 - $6,000 • 65% above $6,000
	Non-preferred brand drugs	$50 deductible	$50 deductible	• 100% for the first $1,800 • 50% $1,801 - $6,000 • 65% above $6,000
	Specialty drugs	$50 deductible	$50 deductible	• 100% for the first $1,800 • 50% $1,801 - $6,000 • 65% above $6,000
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	5% coinsurance	5% of allowed amt + disallowed amt	---none---
	Physician/surgeon fees	No charge	Disallowed amt	---none---
If you need immediate medical attention	Emergency room services	No charge	Reasonable amount for medical necessity	---none---
	Emergency medical transportation	20% coinsurance	20% of allowed amt + disallowed amt	---none---
	Urgent care	No charge	Disallowed amt	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	5% coinsurance	5% of allowed amt + disallowed amt	The Plan will allow $1,215 per day for non-emergency inpatient stay in an out-of-network hospital.
	Physician/surgeon fee	5% coinsurance	5% of allowed amt + disallowed amt	---none---

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 mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	Disallowed amt	---none---
	Mental/Behavioral health inpatient services	No charge	Disallowed amt	---none---
	Substance use disorder outpatient services	Not covered	Not covered	Treatment of substance abuse and/or alcoholism is not covered by the Plan.
	Substance use disorder inpatient services	Not covered	Not covered	Treatment of substance abuse and/or alcoholism is not covered by the Plan.
If you are pregnant	Prenatal and postnatal care	No charge	Disallowed amt	---none---
	Delivery and all inpatient services	5% coinsurance	5% of allowed amt + disallowed amt	---none---
If you need help recovering or have other special health needs	Home health care	5% coinsurance	5% of allowed amt + disallowed amt	---none---
	Rehabilitation services	No charge	Disallowed amt	Speech therapy coverage is limited to $22.50/visit (Out-of-Network).
	Habilitation services	No charge	Disallowed amt	Speech therapy is not covered for developmental and/or learning disorders.
	Skilled nursing care	5% coinsurance	5% of allowed amt + disallowed amt	---none---
	Durable medical equipment	5% coinsurance	5% of allowed amt + disallowed amt	Replacement allowed no more than once every six (6) years.
	Hospice service	5% coinsurance	5% of allowed amt + disallowed amt	---none---

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 your child needs dental or eye care	Eye exam	No charge for one exam every 12 months.	No charge for one exam every 12 months.	---none---
	Glasses	$200 every 12 months for glasses or contact lenses.	$200 every 12 months for glasses or contact lenses.	---none---
	Dental check-up	Amount that exceeds allowance of $44.45 per cleaning.	Amount that exceeds allowance of $44.45 per cleaning.	Allowed three times per calendar year.

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.)

- Long-term care
- Routine foot care
- Weight loss program
- Cosmetic surgery
- Non-emergency care when traveling outside the U.S.
- Substance use disorder inpatient services
- Infertility treatment
- Private-duty nursing
- Substance use disorder outpatient services

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 if performed by a medical doctor
- Hearing aids up to $1,000 per device every 36 months
- Chiropractic care
- Routine eye care (Adult) up to $200 every 24 months
- Dental care (Adult)
- Coverage provided outside the United States. See www.scptac.org.

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 1-800-595-7473. 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: Southern California Pipe Trades Administrative Corporation at 1-800-595-7473 or www.scptac.org 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.**

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** $7,140
- **Patient pays** $400

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	$50
Copays	$0
Coinsurance	$200
Limits or exclusions	$150
Total	**$400**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,235
- **Patient pays** $1,165

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	$300
Copays	$0
Coinsurance	$565
Limits or exclusions	$300
Total	**$1,165**

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.