DC 16 H&W Fund:Blue Cross Network Retiree Direct Pay PPO Plan Coverage Period:01/01/2017–12/31/2017

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

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.dc16trustfund.org** or by calling **1-800-922-9902**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	PPO Provider and Non-PPO Providers: **$300**/person; **$600**/family. Does not apply to PPO preventive care, PPO office visits, hearing aids, hospice care, ambulance, emergency room, chiropractic care and outpatient prescription drugs. Copayments, a penalty for failure to obtain prior authorization and charges over the maximum allowable charge do not count toward the **deductible**.	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?	**No.**	You don't have to meet **deductibles** for specific services but see the chart starting on page 2 for other costs for services this Plan covers.
Is there an out-of-pocket limit on my expenses?	The **Out-of-Pocket Limit** for PPO copayments, coinsurance and deductibles per calendar year is **$3,500**/person; **$7,000**/family. The **Out-of-Pocket limit** on In-Network prescription drugs is **$3,100**/person; **$6,200** family per calendar year.	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 pay for health care expenses.
What is not included in the out–of–pocket limit?	The **Out-of-Pocket Limit** for in-network cost-sharing does not include premiums, non-covered expenses, charges in excess of benefit maximums and allowed charges, a penalty for failure to obtain precertification, dental & vision plan expenses, outpatient retail/mail order prescription drug expenses, amounts exceeding the reference based price, and out-of-network deductibles, copayments and coinsurance except ER visit in cases of an emergency. The **Out-of-Pocket Limit** for In-Network prescription drugs does not include premiums, non-covered expenses, charges in excess of benefit maximums, dental & vision plan expenses, medical expenses, and out-of-network copayments and coinsurance.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. For a list of **PPO providers, see www.anthem.com/ca or call the Trust Fund Office at 800-922-9902.** For a list of Anthem Blue Card providers **outside of California**, see **www.bluecares.com** or call **800-810-2583.** For mental health and chemical dependency benefits, contact **Beat it!** at 1-800-828-3939.	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**.

Questions: Call **1-800-922-9902** or visit us at **www.dc16trustfund.org**. 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.

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 PPO **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use A PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment/visit (** waived if Care Counseling Service is called prior to receiving services) after deductible met	Primary Care, Specialist and Acupuncture: 50% coinsurance after deductible met. Chiropractor: $20 copayment/visit (no deductible)	In this chart, where you see "**", it means that Medicare eligible retirees do not need to comply with the requirement.
	Specialist visit			
	Other practitioner office visit			Chiropractor: maximum benefit is 25 visits/year, x-ray maximum $200/year and medical supply maximum $50/year. Acupuncture: maximum benefit is 25 visits/year.
	Preventive care/screening/ immunization	No charge after deductible met	50% coinsurance after deductible met	Plan covers preventive services and supplies required by the Health Reform law at PPO Providers at no charge, deductible waived. Age and frequency guidelines apply to covered preventive care

Common Medical Event	Services You May Need	Your Cost If You Use A PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	$20 copayment/provider (** waived if Care Counseling Service is called prior to receiving services) after deductible met	50% coinsurance after deductible met	Lab services obtained in the office but sent to a free-standing lab for processing require separate lab copay.
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available from WellDyneRx . Call Member Services at 888-479-2000, option 5 or see the following website: www.welldyneRx.com	Formulary drugs	Retail Pharmacy for 30-day supply: $4 copayment; Mail Order for 90-day supply: $8 copayment/fill.	You pay 100% of the cost of the drug and submit a claim to Prescription Solutions for reimbursement. Plan will reimburse (after applicable copay) what it would have paid at a network pharmacy. This means if the drug is not on the formulary, there is no coverage available.	• Maintenance medications are not covered at a retail pharmacy except for an emergency. • If the cost of the drug is less than the copayment, you pay just the drug cost. • Your Physician can request a formulary exception if you are not able to take a formulary drug. • Prescription contraceptives: no charge for formulary drugs (or non-formulary if the formulary drug is medically inappropriate).
	Non-Formulary drugs	You pay 100% of the cost of a drug not on the formulary.		
	Specialty drugs	Retail: $20 copayment/fill plus 20% of cost of the drug	Not covered	For information on specialty drugs call (888) 479-2000
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$20 copayment/visit (** waived if Care Counseling Service is called prior to receiving services) after deductible met	25% coinsurance after deductible met, plus any amount over $350 per day.	** Arthroscopy, cataract surgery and colonoscopies at an outpatient surgical center are subject to a Maximum Allowable Charge. Benefits to Non-PPO providers are limited to a maximum of $350 per day.
	Physician/surgeon fees	$20 copayment/visit (** waived if Care Counseling Service is called prior to receiving services) after deductible met	50% coinsurance after deductible is met	---none---

Common Medical Event	Services You May Need	Your Cost If You Use A PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$100 copayment/visit (no deductible)	$100 copayment/visit (no deductible)	Copayment waived if transported to the hospital by ambulance
	Emergency medical transportation	$100 copayment/trip (no deductible)	$100 copayment/trip (no deductible)	---none---
	Urgent care	$20 copayment/visit (** waived if Care Counseling Service is called prior to receiving services)	50% coinsurance after deductible met	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	80% coinsurance after deductible met	50% coinsurance after deductible met	** If prior authorization is not obtained before non-emergency admission, Plan will pay 75% of its usual payment for facility charge. Total hip and knee replacements are subject to the a maximum of $30,000
	Physician/surgeon fee	No charge after deductible met	50% coinsurance after deductible met	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge after deductible met	50% coinsurance after deductible met	---none---
	Mental/Behavioral health inpatient services	80% after deductible met	50% coinsurance after deductible met	** If prior authorization is not obtained before a non-emergency admission the Plan will pay only 75% of its usual reimbursement for the facility charge
	Substance use disorder outpatient services	No charge after deductible met	50% coinsurance after deductible met	---none---
	Substance use disorder inpatient services	80% after deductible met	50% coinsurance after deductible met	**If prior authorization is not obtained before a non-emergency admission the Plan will pay only 75% of its usual reimbursement for the facilities charge

Common Medical Event	Services You May Need	Your Cost If You Use A PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	No charge after deductible met (deductible waived for preventive care)	50% coinsurance after deductible met	No charge for many screening services necessary for prenatal care. Ultrasound payable as a diagnostic test
	Delivery and all inpatient services	80 % after deductible met	50% coinsurance after deductible met	**Prior authorization required only if hospital stay is more than 48 hours for vaginal delivery or 96 hours for C-section
If you need help recovering or have other special health needs	Home health care	$10 copayment/visit after deductible met	50% coinsurance after deductible met	Maximum benefit of 100 visits/calendar year
	Rehabilitation services	$20 copayment/each provider (**waived if Care Counseling Service is called prior to receiving services) after deductible met	50% coinsurance after deductible met	Maximum of 25 visits/year for Rehab Services (physical, occupational and speech therapy). **Contact Care Counseling for preapproval of any additional visits.
	Habilitation services	Not covered	Not covered	You pay 100% of these expenses.
	Skilled nursing care	80% after deductible met	50% coinsurance after deductible met	Maximum benefit of 100 days/year
	Durable medical equipment	No charge after deductible met	50% coinsurance after deductible met	**Call the Care Counseling Service for authorization before you receive durable medical equipment
	Hospice service	No charge after deductible met	50% coinsurance (deductible waived)	Covered if terminally ill
If your child needs dental or eye care	Eye exam	Not covered	Not covered	You may have benefits through a separate dental or vision plan, which are not subject to Health Reform.
	Glasses	Not covered	Not covered	
	Dental check-up	Not covered	Not covered	

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.)

- Cosmetic surgery
- Dental care (available under separate Delta Dental plan)
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Non-formulary drugs
- Private duty nursing
- Routine eye care (available under separate VSP plan)
- Weight loss programs (except preventive services required by Health Reform)

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 (up to 25 visits/year).
- Bariatric Surgery (if approved as medically necessary)
- Chiropractic care (up to 25 visits per year).
- Hearing aids ($800/device every 48 months)
- Routine foot care (covered for insulin dependent diabetics)

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 (800) 922-9902. 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 1-800-922-9902. You may also 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 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 (800) 922-9902.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 922-9902.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** (800) 922-9902.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 922-9902.

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** $6,020
- **Patient pays** $1,520

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	$300
Copays	$110
Coinsurance	$1,080
Limits or exclusions	$30
Total	**$1,520**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $5,000
- **Patient pays** $400

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	$0
Copays	$320
Coinsurance	$0
Limits or exclusions	$80
Total	**$400**

For Medicare eligible Retirees: Please note that the coverage examples do not reflect what the patient or plan would actually pay because this plan only pays secondary to Medicare.

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.

5460497v4/10509.001